

Reclaiming Sexuality Through Art:
Art Therapy Applications and Recommendations in Adolescent Psychiatric Facilities with
Patients who have a History of Trauma

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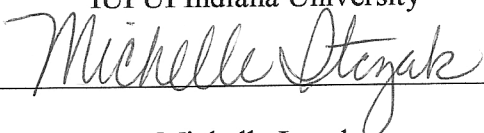
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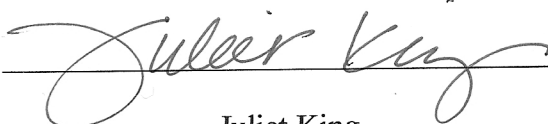
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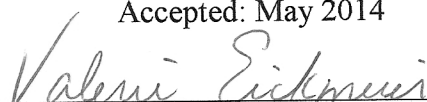

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Abstract

This thesis utilizes an integrative review of literature to examine how art therapy interventions can be used to explore sexuality and assist in reducing sexual misbehaviors for adolescents in a residential psychiatric facility with a history of trauma. Adolescents in residential psychiatric facilities often lack the means to explore and understand their sexuality due to rules and regulations that must be in place as a protective measure. Lacking the means to explore sexuality, however, may lead to sexual misbehaviors. Through a search of the literature, it was discovered that there is a gap in research using art therapy in this specific context. Through an exploration of the topics of mental illness, art therapy, sexuality, and trauma, previous research and writings are integrated into the conceptualization of the potential benefits and challenges that would come from the exploration of sexuality through art therapy with this population. This is followed by an outline of an art therapy treatment plan that addresses the exploration of sexuality that could be used with adolescents in residential psychiatric facilities. This treatment plan is supported by conclusions based on the integrative literature review. It is recommended that through an understanding of the integrated information and the treatment plan, art therapists can implement this plan with this population and study its effectiveness in reducing sexual misbehavior in the population.

Keywords: adolescence, art therapy, residential psychiatric, sexuality, trauma

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Chapter I: Introduction

Adolescents in residential psychiatric facilities often lack the means to explore and understand their sexuality due to rules and regulations that must be in place as a protective measure. Residential psychiatric facilities limit the ability to express or explore sexuality through rules and regulations about sexual behavior and discussions of sexuality among patients (Mauritz, Goossens, Draijer, & van Achterberg, 2013; Weisbrot, 1986). Adolescents who enter psychiatric facilities are likely to have experienced trauma at some point in their lives (Havens et al., 2012; LeBel & Stromberg, 2006; Lipschitz, Winegar, Hartnick, Foote, and Southwick, 1999; Weine, Becker, Levy, Edell, & McGlachan, 1997). The prevalence of trauma history for adolescents who are in residential facilities underlies the need for these rules in order to avoid additional traumatic experiences or retraumatization in the facility, but these rules may also hinder healthy exploration of sexuality (Havens et al., 2012; Lipschitz et al., 1999; Weine et al., 1997; Weisbrot, 1986). By not understanding or exploring issues of sexuality, adolescents in the residential setting may act out through physical aggression or sexual misbehavior (Weisbrot, 1986). This creates a perpetual cycle of not understanding sexuality, and then being reprimanded when these impulses are acted upon, leading to an attempt to further repress feelings of sexuality and avoidance of exploring the topic.

In many adolescent residential facilities, patients participate in verbal therapy sessions as part of their treatment; however, sexuality is not easily understood through verbal exploration for many people, particularly adolescents. Taboos surrounding sexuality, especially adolescent sexuality, may hinder potential verbal exploration (Realmuto & Erickson, 1986). Additionally, sexuality is an innate human experience, which we feel affectively and bodily; these experiences, by the nature in which our brain stores them, are difficult to verbalize (Bancroft, 2010). Studies

in recent years have demonstrated the necessity of addressing sexuality in the process of providing holistic care for patients in psychiatric hospitals (Quinn & Browne, 2009; Quinn, Happell, & Browne, 2011; Quinn, Happell, & Welch, 2013).

Sexuality can be understood as a part of one's being that is complex and involves social, psychological, physical, emotional, and spiritual components of one's self (McCann, 2000). Because of this, it is conceivable that therapists in a psychiatric setting should address the innate human experience of sexuality with their patients in order to allow those patients to fully understand themselves. The literature on residential adolescent psychiatric facilities does not clearly outline how to approach and care for the developing needs of sexuality of children and adolescents. Though there seems to be little contemporary research discussing sexuality in the adolescent psychiatric population, this topic was addressed by Realmuto and Erickson (1986) as well as Wiesbrot (1986). Both articles addressed the need for adolescents to understand their own sexuality, and both articles suggested utilizing symbolic or unconscious means, such as art therapy, in order to facilitate this understanding (Realmuto & Erickson, 1986; Wiesbrot, 1986).

Art therapy has been documented as a way to connect to one's sexuality, but it does not seem that it has been used specifically to help adolescents in residential treatment facilities who have experienced trauma to connect to their sexuality (Ambrogne-O'Toole, 1988; Grenadier, 1995; Junge, 1987; Powell & Faherty, 1990). In order to do this, one must consider the work in art therapy thus far with adolescents who have experienced trauma due to the prevalence of trauma history for adolescent psychiatric patients and the connection of trauma to one's experience of sexuality (Kristensen & Lau, 2011; Klorer, 2005; Pifalo, 2002; Weine et al., 1997). Pifalo (2006) worked with adolescent girls with a history of sexual abuse and showed that implementing art therapy in treatment reduced symptoms of posttraumatic stress disorder

(PTSD). Klorer (2005) discussed how art therapy accesses the parts of the brain where traumatic experiences are stored and emphasizes the value of practicing art therapy with maltreated children. The current study will further outline the connection between trauma, sexuality, and mental illness and show that contributions from art therapy experts, including Klorer (2005) and Pifalo (2006), can support the use of art therapy as a means to explore sexuality.

This study aims to answer the question, “How can art therapy be used as a means to explore sexuality and assist in reducing sexual misbehaviors for adolescents in a residential psychiatric facility with a history of trauma?” This seeks to be accomplished through an integrative literature review that addresses topics of sexuality, adolescence, art therapy, mental illness, and trauma. The data gathered from the literature will then be analyzed through a content comparison approach in order to identify common themes and patterns (Whittemore & Knafl, 2005). As a result of this analysis, art therapy interventions will be established and suggested for the population that can be used to explore sexuality. The inquiry focuses specifically on adolescents in residential psychiatric facilities who have experienced trauma, so findings may be limited to this population and may not be applicable outside of this population. This research must take into consideration the impact of trauma on an adolescent’s understanding of sexuality due to the prevalence of trauma history in this population and the connection between trauma and sexuality (Ace, 2007b; Kristensen & Lau, 2011; Lipschitz et al., 1999; Weine et al., 1997). This becomes a further limitation of the study because some adolescent residential psychiatric patients have no trauma history. As a result of this study, art therapists may want to implement the exploration of sexuality into their practice with adolescents in residential psychiatric facilities.

In exploring the issues surrounding a lack of understanding of sexuality for adolescent residential psychiatric patients, this literature review will address the problem of sexual misbehavior in the residential psychiatric setting and its potential to retraumatize patients. The verbal discussion of sexuality can prove to be difficult for both patients and staff, and it is hypothesized that art therapy can overcome some of these barriers due to the nonverbal quality of art therapy. Art therapy will be suggested as a way to provide adolescents a healthy means to understand and explore sexuality, which in turn will theoretically reduce sexual misbehaviors in adolescent psychiatric facilities. This may encourage art therapists in residential psychiatric facilities to assist their patients in the exploration of sexuality through art therapy in order to avoid the issues surrounding sexuality in this population.

Definitions

Adolescence: The time of life spanning between puberty, the biological changing of the body, and adulthood, which is socially defined, approximately from the age of 10 to 20. (Auslander, Rosenthal, & Blythe, 2006; Berger, 2010).

Liminality: Liminality is a term rooted in social anthropology, and refers to a transitional phase involved in rites of passage and life events such as marriage, death, and childbirth (Haywood, 2012). Liminality is a state of ambiguity in which one has neither finished with one life stage nor entered into a new life stage (Haywood, 2012).

Mental Illness: This term will be used to describe what the American Psychiatric Association (2013) calls a “mental disorder,” which is defined as the following:

A syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (p. 20).

Residential Psychiatric Facility:

A specialized, 24-hour living environment that offers psychological, educational, social, recreational, psychiatric, and medical therapeutic services to youth with severe emotional disturbances. Patients admitted to this type of care require an intensity of structure, protection, and psychotherapeutic treatment that cannot be offered on an outpatient basis (Willis & McCay, 2002, p. 32).

Sexual Behavior: “This means actions, language or visual materials which specifically refer to, portray or involve sexual activity or language. Conduct of a sexual nature may include overt sexual solicitations, inappropriate touching, sexual jokes and inquiries about a person’s sex life” (Thomas, Park, Ellingen, Ellison, Menanteau, & Young, 2011, p. 145).

Sexual Health: According to the World Health Organization (2006):

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p. 5)

Sexual Misbehavior: Sexual behavior or sexually charged statements that are prohibited by the residential facility, which could include sexual assault, the threat of sexual assault, indecent exposure, or a verbalization that is overly personal and eludes to a sexual act. (Hughes & Hebb, 2005).

Sexuality: Sexuality encompasses many aspects of the self. It includes the physical act of sex as well as the way we relate to others in an emotionally sexual way. It involves the emotions, cognition, and physical attributes that align with our values, attitudes, and self-awareness in relation to sex (Hughes & Hebb, 2005; McCann, 2000).

Trauma: Trauma can be considered an incident in which a “person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence” (American Psychiatric Association, 2013, p.271). Trauma will be used in this thesis as a term referring to emotional abuse, emotional neglect, physical abuse, physical neglect, sexual abuse, exposure to domestic violence, and/or exposure to community violence. Instances in which specific types of trauma are being discussed will be noted.

Chapter II: Methods

This integrative literature review consisted of using databases available through Indiana University-Purdue University Indianapolis's (IUPUI) library. No human participants were used for this study. The literature search included a search of all databases available through EBSCOhost. A list of databases accessed through EBSCOhost as well as some other databases and specific journals that were searched are listed in Table 1. A search of IUPUI WorldCat was used to find books of relevance, which is a tool to search for library holdings at IUPUI and worldwide. A secondary search was conducted using references from articles found through initial searches.

Table 1

Databases and Journals from Which References were Retrieved

Databases	Journals
CINAHL Plus with Full Text	Art Therapy: Journal of the American Art
ERIC	Therapy Association
Family Studies Abstracts	The Arts in Psychotherapy
Health Source: Nursing/Academic Edition	The International Journal of Art Therapy
MEDLINE	
PsychINFO	
Web of Science	

Terms used to search for information (and their various derivatives and combinations) included art therapy, sexuality, trauma, adolescents, and inpatient. The asterisk (*) was used with some terms in order to produce search results that contained words with the root or stem that

preceded the asterisk. Table 2 includes a list of terms used in the research process. When searching databases, searches were limited to scholarly (peer reviewed) journals and articles written in English. Some searches required an inclusion of the age group of adolescents (13-18 years old), but some articles that focused on adults were also included. The year of publication was not limited in these searches, and the years of publication for sources gathered are replicated in Table 3.

Table 2

Search Terms and Phrases in Alphabetical Order

Adolescent	Inpatient	Sexuality	Art Therapy	Trauma
Adolescen*	Inpatient	Sex*	Art Therapy	Brain
Adolescent	Psych*	Sexual	Art therapy	Emotional
Puberty	Psychiatric	development	with abuse	abuse
Teen*	Psychiatric patients	Sexuality	victims	Neglect
Youth	Residential psych*	Sexuality	Art Therapy	Physical abuse
	Residential	development	with adolescents	Sexual abuse
	psychiatric		Art Therapy	Trauma
			with teens	

Table 3

Publication Dates of Resources

Publication Date	Number	Percentage
2010-2014	21	23.3
2000-2009	44	48.9
1990-1999	15	16.7
1980-1989	6	6.7
Pre - 1980	4	4.4
Total	90	100

Research was not limited to the field of art therapy. Work from psychiatric nursing, pediatric and adolescent nursing, sex psychology, pediatric and adolescent psychology, psychiatry, and trauma theory were also fields that provided useful research for this literature review.

This study utilized an integrative literature review method due to the need to gather and connect information from previous research before a study involving human subjects could be thorough and effective. There is a recognizable gap in research about the use of art therapy to explore sexuality in a residential psychiatric facility and the considerations and effects of this type of treatment. By setting up a foundation of theory for this type of work, future studies could implement the recommendations of this study in the adolescent residential psychiatric population. Due to the vulnerability of this population, the sensitive issue of sexuality, and the potential for traumatic experiences to be elicited through this work, this is not a study that should

be implemented with human subjects without a strong foundational understanding of art therapy, sexuality, and trauma theory and the complex relationships that exist between these theories.

In using an integrative literature review methodology, one “summarizes past empirical or theoretical literature to provide a more comprehensive understanding of a particular phenomenon” (Whittemore & Knafl, 2005, p. 546). The analysis of the literature in this study is best explained through a content comparison approach. Through this, data extracted from research will be converted into “systematic categories, facilitating the distinction of patterns, themes, variations, and relationships” (Whittemore & Knafl, 2005, p. 550). The literature gathered is reviewed for the experience of sexuality by people who are diagnosed with a mental illness, people who participate in art therapy, and people who have experienced trauma. The literature also provides perspectives from mental health professionals, including art therapists, about their observations and contributions to the understanding of sexuality among the previously outlined populations. There will be an exploration of the topics of mental illness, art therapy, sexuality, and trauma, in order to provide a context for these experiences. In order to be sure the research that is used is valid, the methodology of research gathered will be evaluated in order to determine that quality literature is used.

Data will first be compared in order to identify patterns, themes, and/or relationships (Whittemore & Knafl, 2005). In order to address possible threats to validity in the data analysis phase, assumptions will be made clear, any interpretation rules will be defined, and evidence that is based on only a single study will be denoted as such (C. Russell, 2005). The data will be divided into subgroups and information in each subgroup will be analyzed. Conclusions will then be drawn based on a summary of the analyses of the subgroups. This literature review will then develop a suggested treatment outline for utilizing art therapy in order to explore sexuality for

adolescent patients in residential psychiatric facilities based on conclusions drawn from the data analysis.

Chapter III: Literature Review

Adolescent Psychiatric Facilities

A mentally ill child or adolescent should be treated in the safest and least restrictive environment possible, and community-based treatment should always be considered before resorting to inpatient treatment (Houston et al., 2010). When community-based treatment is considered inappropriate for the safety needs of the child or community-based treatment has not been successful, the child or adolescent may need a more restrictive environment in which the child leaves the home and lives in a residential psychiatric facility (Houston et al., 2010).

Adolescents or children who enter residential psychiatric facilities pose a significant danger to themselves or others (Willis & McCay, 2002). Adolescent psychiatric facilities are able to monitor youth who posed a danger while in the community and ensure that they remain safe, and the facilities additionally provide a multitude of services. Treatment programs often perform a comprehensive evaluation of the adolescent's emotional, behavioral, medical, educational, and social needs (American Academy of Child and Adolescent Psychiatry (AACAP), 2011). The practitioners at the facilities then create an individualized treatment plan based on goals specific to the patient and meet weekly to assess the effectiveness and progress of treatment in order to modify treatment when necessary (AACAP, 2011; Houston et al., 2010).

Psychiatric facilities offer group, individual, and family therapies along with psychiatric care to find psychotropic medications that may help the child with their mental illness (AACAP, 2011). In addition to psychiatric treatment, psychiatric facilities provide access to on-going education and services to meet the patient's medical and social needs (Houston et al., 2010). Patients in psychiatric facilities often spend their days in school, therapy, and recreational activities. In addressing social needs in residential treatment, patients may be able to learn

appropriate physical and verbal boundaries during social interactions and enhance their communication and conflict resolution skills. Treatment at psychiatric facilities should maximize contact and therapeutic interventions between the patient and family in order to prepare them to successfully reenter the home once they are deemed safe to live in the community (Houston et al., 2010). Psychiatric facilities also prepare ongoing, community-based care for the patient once they leave the facility (Houston et al., 2010).

As patients work toward their treatment goals, they are likely to continue to exhibit the dangerous behavior that led to their admission to the psychiatric facilities. Staff that work at psychiatric facilities are trained in de-escalation techniques, which are used to help patients reduce stress and anger before they become dangerous to themselves or others (Masters et al., 2002). De-escalation techniques may include providing patients with choices and control in order to enhance intrinsic motivation during emotional crises (Conte, Snyder, & McGuffin, 2008). When de-escalation techniques are unsuccessful or impractical, the staff may implement seclusion or restraint techniques in order to maintain the safety of the patient or the safety of other patients and staff (Masters et al., 2002). Any de-escalation technique may be done in combination with psychotropic medication in instances of extreme agitation (Masters et al., 2002). The process of seclusion involves a patient entering an isolated room away from other patients or staff so they are not in the position to harm others (Masters et al., 2002). Seclusion is preferable to restraint because it involves greater autonomy, but in cases in which patients are likely to harm themselves, seclusion may not be a viable de-escalation option (Masters et al., 2002). Restraint may involve the physical holding of a patient by two or more staff or placement in a mechanism that can adequately and humanely restrain patients from harming themselves or others, commonly a bed or chair created for the purpose of restraining psychiatric patients

(Masters et al., 2002). Seclusions and restraints must be monitored in order to assure the patient's vitals remain in a safe range and the patient's physical and psychological needs are continuously met (Masters et al., 2002).

Treatment, trauma, and cognitive functioning. Cognitive functioning must be taken into account when implementing systems of treatment, and trauma histories may be a factor in impaired cognitive functioning. The majority of adolescents and children admitted to inpatient psychiatric facilities have experienced at least one type of traumatic event in their lives. In a study of diagnoses that are comorbid with PTSD, Lipschitz et al. (1999) found that 93% of the 74 adolescent inpatients had been exposed to at least one traumatic event, including witnessing community or family violence and being a victim of physical, sexual, or community violence. In a study of the medical records of 140 adolescent psychiatric patients, 96.4% had been exposed to at least one traumatic event, and on average they had been exposed to multiple traumatic events (Havens et al., 2012). Weine et al. (1997) also studied the prevalence of trauma histories in adolescent inpatients and found 81% of the 75 adolescents in the study had experienced at least one incident of trauma. Through a point in time medical record review, Massachusetts found 84% of their adolescent inpatient population had experienced at least one traumatic event (LeBel & Stromberg, 2006). These statistics highlight the prevalence of trauma exposure among adolescent psychiatric patients and provide support for the necessity of considering the effects of trauma when developing treatment for adolescent psychiatric patients.

Delaney (2006) highlighted the consideration of trauma when she explained ways in which Social learning theory (SLT) can be applied in the treatment of child and adolescent psychiatric patients. SLT proposes that behavior is influenced not only by stimulus-response sequences, but also by cognitive factors, such as perceptions and attributions (Delaney, 2006).

Stone (as cited in Delaney, 2006) indicated an important aspect of SLT is that people learn behavior through observations of the behaviors of others and understanding the thought process that led to the behaviors of others. Delaney (2006) explained, “Children are constantly learning from others about how to think about the world” (Delaney, 2006, p. 184). Through children’s memories of experiences, they apply learned behavior to new experiences that are similar to past experiences (Delaney, 2006). This process requires an ability to formulate memories, understand and remember intentions, read facial cues, generate constructive responses to behavioral intervention, and control impulses (Delaney, 2006).

Children and adolescents who experience trauma have exceptional difficulty with these tasks. For example, trauma can inhibit the working memory of children and adolescents, which inhibits their ability to apply learned behaviors to new situations (Burgess, Hartman, & Clements, 1995). Delaney (2006) suggested ways to encourage the development of working memory, such as encouraging patients to journal about situation-affect-thought behavior links and interrupting negative behaviors to build impulse control. Silverstein et al. (2006) encouraged staff to not respond or acknowledge adverse behavior in adult patients, but for children and adolescents it may be vital to engage when adverse behavior is exhibited because they have limited knowledge of alternative behaviors. Delaney (2006) encouraged positive reinforcement for self-awareness of behaviors so that the child or adolescent may continue the practice of self-awareness, which may enhance their ability to apply learned behaviors.

Mohr and Pumariega (2004) discussed the level systems often utilized in psychiatric facilities to implement positive reinforcement for participating in assigned activities. If the patient does not participate, the consequence is a limitation of privileges (Mohr & Pumariega, 2004). The authors denoted that there was a lack of empirical evidence supporting the level

systems often used in psychiatric facilities, and the systems did not consider individual motivations or differences in patients based on demographics or cognitive functioning (Mohr & Pumariega, 2004). Mohr and Pumariega (2004) suggested that interventions for behavior management should be individualized rather than generalized. Groot (2009) also recognized differences in patients should require more differentiation in treatment. She found in a study of 113 youth in residential psychiatric treatment that the ability to implement social skills, or social competence, was negatively correlated with behavior problems. Groot (2009) concluded that effective treatment should include a more specific understanding of social developmental stage and treatment should be based on individual factors. This would include an adaptation of interventions to meet the individual developmental needs and interpersonal skills of clients rather than implementing generalized interventions that are geared towards a normative developmental stage (Groot, 2009). Adaptations in treatment should consider trauma exposure and its effect on cognitive functioning (Delaney, 2006).

Social learning theory and token economies. Systems of treatment and regulations used in psychiatric facilities have been studied in order to ensure the facilities are doing their best to treat these patients. SLT has been used to develop treatment programs in psychiatric hospitals, which are often referred to as token economies (Menditto, Baldwin, O'Neal, & Beck, 1991; Paul & Lentz, 1977; Silverstein et al., 2006). Fuoco, Lawrence, and Vernon (1988) studied the lasting effectiveness of token economy systems, verbal praise, and self-monitoring in an adult residential treatment program. In a token economy system, tokens are given when patients exhibit target behaviors, and the tokens can be reimbursed for food or other privileges (Fuoco et al., 1988). In the experiment, 24 patients were placed in five conditions, which provided tokens or verbal praise for completing goal behavior, educated on self-monitoring goal behavior, or

combined tokens with verbal praise or goal behavior (Fuoco et al., 1988). The researchers measured the completion of goal behaviors while treatment was administered as well as completion of goal behaviors one week after the experimental treatment was terminated (Fuoco et al., 1988). The results of the study showed that patients in the token reinforcement conditions did not maintain the same level of completion of goal behavior as they did during the treatment phase (Fuoco et al., 1988). Verbal praise seemed to be the reinforcement that maintained the most after the treatment phase (Fuoco et al., 1988). Though this study was used for adults, it leaves psychiatric treatment facilities to assess the effectiveness of token economy systems. Following treatment, modified adverse behaviors should continue outside the psychiatric facility.

Through assessing treatment programs, psychiatric facilities can continue to develop treatment programs that modify adverse behavior in a way that lasts after treatment is terminated. In order for treatment programs to be successful, all staff must consistently enforce intervention programs. Silverstein et al. (2006) explained multiple aspects of a program based on social learning, including staff roles, program groups, behavior contracts, positive reinforcements, and techniques for managing inappropriate behaviors. The program was implemented with adult patients diagnosed with schizophrenia that entered an inpatient hospital program following discharge from a state psychiatric hospital (Silverstein et al., 2006). Silverstein et al. (2006) outlined ways to improve attentiveness and active participation, which are difficult tasks for patients with cognitive difficulties. In addressing cognitive difficulties, Silverstein et al. (2006) addressed the need for alterations in interventions based on individual needs much like Groot (2009) recommended. In order to promote social support for target behaviors, Silverstein et al. (2006) recommended awarding tokens, praise, and points in the presence of other patients when possible. This allowed other patients to model appropriate behaviors of their peers and learn the

sequence of appropriate behavior followed by positive reinforcement. Silverstein et al. (2006) found that after the implementation of the program, the patients exhibited increased compliance with cleaning tasks and activities of daily living, such as grooming. There was also evidence that the program decreased incidents of verbal and physical aggression, although the degree of change varied between patients (Silverstein et al., 2006). The number of seclusions and restraints decreased after the implementation of the program (Silverstein et al., 2006). Silverstein et al. (2006) stressed that staff compliance and consistency in program implementation is key to program success, and outlined instances in which staff noncompliance may have inhibited success.

Adolescents look to peers for behavior modeling and praise for behaviors (Delaney, 2006). Psychiatric facilities can use SLT to increase target behaviors of patients by encouraging patients who are successful in treatment to encourage their peers to engage in similar behavior. This concept has been used in guided group interaction programs with the juvenile delinquent population. Through guided group interaction, peers, rather than staff, discourage adverse behaviors in the group setting (Richardson & Meyer, 1972). Guided group interactions allow for groups to develop moral standards for all members of the group, encouraging members to look to each other for standards of behavior, and allowing for peer encouragement and praise for positive behavior (Richardson & Meyer, 1972).

Treatment outcomes. In order to find patterns of outcomes for children and adolescents in residential psychiatric treatment, Frensch and Cameron (2002) reviewed previous outcome studies of residential treatment. Through their literature analysis, Frensch and Cameron (2002) found that there are many methodological shortcomings in these studies, which resulted in any conclusions to be made with caution. Though residential treatment seems to improve the

functioning of some children and adolescents, these improvements do not always remain consistent over time (Frensch & Cameron, 2002). The authors conclude, “Successful patterns of adjustment appear to hinge on two factors: the posttreatment environment to which a child or youth is discharged, and the degree of family involvement during treatment” (Frensch & Cameron, 2002, p. 335).

Hair (2005) also completed a literature review in order to analyze research of treatment outcomes for children and adolescents after residential treatment between 1993 and 2003. Rosen (as cited in Hair, 2005) explained that the residential psychiatric facility provided patients with a “consistent, nurturing environment with predictable, consistent expectations that are designated to help shape desirable behaviors and emotional responses” (p. 555). For Hair’s (2005) study, successful discharge included a desirable emotional and behavioral change, completion of programming, and movement into a less restrictive setting. Similar to the study by Frensch and Cameron (2002), Hair (2005) found that family involvement and after care services contributed to successful discharge. Additional factors in successful discharge included shorter lengths of stay, academic success, and the therapist-client relationship (Hair, 2005). The finding that family involvement is a significant factor in successful discharge from residential psychiatric facilities supports treatment guidelines from the AACAP to maximize family contact and therapeutic involvement for children and adolescents in psychiatric facilities (AACAP, 2011; Houston et al., 2010). High levels of family dysfunction have been shown to be a predictive factor in residential psychiatric placement, and through maximizing inclusion of the family in the psychiatric treatment of the treatment facilities, the child may successfully discharge from the facility with a diminished likelihood of reentering a residential treatment facility (Park, Jordan, Epstein, Mandell, & Lyons, 2009).

Living in a residential psychiatric facility provides a unique environment for development. Patients who are considered to be dangerous to themselves or others while living in the community must enter psychiatric facilities until they are deemed safe to return to the community. The child or adolescent psychiatric patient no longer has easy access to socialization with peers who are not mentally ill, and must comply with extreme restrictions of behavior in order to maintain safety for patients and staff. These facilities must strive to provide adequate and holistic treatment so that patients may learn how to overcome the obstacles of their mental illnesses and live a fulfilling life. In order to provide holistic care, psychiatric facilities attend to psychiatric, medical, spiritual, and social needs. The literature on residential adolescent psychiatric facilities does not clearly outline how to approach and care for the developing needs of sexuality of children and adolescents who have experienced trauma.

Normative Adolescent Sexuality

Since the beginning of the century, researchers have begun to study and address the concept of normal or positive development of sexuality for adolescents through empirical research (Tolman & McClelland, 2011). This research developed parallel to an understanding and acceptance that sexuality development is “integral to adolescent identity formation” (Tolman & McClelland, 2011). Previous research on adolescent sexuality focused on negative outcomes, such as prevalence of sexually transmitted infections (STIs) and teen pregnancy, and intended to provide information and statistics to better guide young people as their sense of sexuality emerges. With an increased number of more recent empirical research studies on normative sexual development that do not solely focus on negative outcomes, practitioners and parents may be able to provide better guidance for young people. S. Russell (2005) explains the complexity of sexual development stating, “An individual adolescent’s personal experience of sexual

maturation is defined both by the emerging young adult body and by shifting interpersonal and social expectations and interactions that characterize daily life” (p. 6). Biological, psychological, and social influences contribute to the development of one’s sexual selfhood.

Biological influences. During puberty, significant biological changes occur that affect physical appearance and the way one’s brain and body functions. Moore and Rosenthal (2006) link puberty and sexuality stating, “Adolescent sexuality is inextricably tied up with the events of puberty in which the adolescent’s body develops its adult shape and reproductive functioning, and hormonal changes affect sex drives in complex ways” (p. 66). Puberty can be understood from a neurological standpoint as the reactivation of the gonadotropin-releasing hormone (GnRH), at which time GnRH increases enough to trigger an increase in gonadotropin hormone and steroid hormone (testosterone and oestrogen) (Moore & Rosenthal, 2006). The releasing of these hormones leads to sexual maturation and the beginning of changes in physical appearance (Moore & Rosenthal, 2006). GnRH initially activates in utero and is responsible for the development of prenatal sex differences; once these differences are established, the secretion of GnRH decreases until it is reactivated at the time of puberty (Biro & Dorn, 2006).

The timing of this reactivation varies individually due to biological and environmental influences (Moore & Rosenthal, 2006). The process of reactivation involves a signal sent from the hypothalamus, part of the hypothalamic-pituitary-adrenal (HPA) axis, to the pituitary gland, which triggers an increase in the release of gonadotropins (Moore & Rosenthal, 2006). Though researchers have not determined the cause of the initial signal from the hypothalamus, Sisk and Foster hypothesized that this event occurs when the person is “sufficiently physically developed, socially linked and in an optimal environment to begin the reproductive process” (as cited by Moore & Rosenthal, 2006, p. 69). The contribution of genetic influences to the onset of puberty

has been shown through studies relating the onset of menarche and a female's first sexual experience to her mother (Miller, Christopherson, & King, 1993). Some environmental conditions can affect the onset of puberty, for instance environmental contaminants can delay the onset of puberty, and for young girls an absent father has been shown to speed up the initiation of puberty (Moore & Rosenthal, 2006). Cultural influences can also affect the timing of puberty, including the cultural expectations associated with the onset of puberty and the teenager's preparation for the onset of puberty (Moore & Rosenthal, 2006).

Hormonal changes at puberty alter the way the brain responds to stimuli. For instance, testosterone may be a protective factor against the stress response by the HPA axis by inhibiting the response of the HPA axis to stressful stimuli (Biro & Dorn, 2006). These changes in the brain are associated with sexuality in that hormone changes can enhance sexual desire, and the hormonal makeup of one's brain can be correlated with initiation of sexual intercourse (Biro & Dorn, 2006). Though biological changes do not explain the entirety of the development of sexuality, these changes must be considered in combination with other factors in order to understand the development of sexuality.

Psychological influences. Adolescents experience sexuality based on many individual factors, but trends that reveal a typical sequence of normative sexual behavior have been identified and investigated. In heterosexual relationships, Smith et al. indicate the typical sequence of heterosexual sexual behavior "starts at around the age of 13 with embracing and kissing, moving through petting or fondling breasts and sex organs, and ending with intercourse" (as cited in Moore & Rosenthal, 2006, p. 8). The movement through this sequence may vary; for instance, African-American girls often experience intercourse before heavy petting (Moore & Rosenthal, 2006). This progression of sexual behavior can be considered a positive and normal

experience for adolescents. Moore and Rosenthal (2006) affirmed, “These experiences provide young people with the opportunities for sexual exploration and discovery, and for acquiring the skills in intimacy which are necessary if one is to establish a long-term partnership” (p. 9).

A study of adolescent couples, age 14 to 21, by Welsh, Haugen, Widman, Darling, and Grello (2005) demonstrated through questionnaires how sexuality related to relationship quality in adolescent romantic relationships. The study revealed that a higher desire for one’s partner was correlated with higher relationship satisfaction and higher commitment (Welsh et al., 2005). Couples that engaged in kissing more frequently were also more committed to the relationship (Welsh et al., 2005). In this study, younger couples that engaged in more frequent intercourse were less satisfied in the relationships; however, there was no correlation between frequency of intercourse and relationship satisfaction for older couples (Welsh et al., 2005). The study by Welsh et al. (2005) empirically demonstrated the concept that physical expression of sexuality in relationships is positively correlated with a higher experience of commitment and satisfaction with one’s partner, and it seems to support the idea that sexual exploration allows for a better understanding of intimacy and partnership (Moore & Rosenthal, 2006).

Through research of the sexual response cycle of sexual desire, sexual arousal, sexual function, and sexual behaviors, Fortenberry (2013) found that there are many similarities between adults and adolescents in respect to this cycle. Sexual thoughts and attraction emerge during early puberty, and it appears that adolescents exhibit signs of conceptualizing choices about sexual behavior as well as the desire to be desired (Fortenberry, 2013). The experience of sexuality in adolescents can be conceptualized as similar to adult sexuality, in that “the subjective interpretation of the experiences of sexuality almost certainly change over the life-course, [but] physiological components such as sexual arousal and orgasm do not” (Fortenberry,

2013, p. 281). Though it is clear that one should not conceptualize adolescent sexuality as equal to that of adults, one should respect adolescents as sexual beings and provide a healthy space for them to explore and understand this sexuality.

Social influences. There are many social influences on sexuality development including one's culture, peers, and social media; however, peers seem to be the most significant social influence on sexuality development. As young people enter the stage of adolescence, they attempt to make decisions outside of their family connections and begin looking to peers for advice and acceptance (Tolman & McClelland, 2011). These peer connections shape the development of sexual norms, attitudes, and behaviors (Tolman & McClelland, 2011). Like other influences on sexuality development, there are many variables in studying social networks, and it is not easy to find clear answers about how complex peer networks influence the development of one's sexuality (Tolman & McClelland, 2011). Sexual decisions in adolescence are scrutinized by others in one's peer group, which means that peer groups can impact when an adolescent begins having sex, the context in which he or she begins having sex, and who he or she has sex with (Smith, Guthrie, & Oakley, 2005). This influential relationship is reciprocal in that as the peer group shapes choices, one's choices may determine the peer group one chooses to be in (Smith et al., 2005). Cultural practices can also impact one's experience of sexuality, for instance, discussing sexuality in the home and premarital sex are culturally unacceptable in Asian cultures, which may delay the onset of an Asian adolescent's initial sexual experience (Moore & Rosenthal, 2006). Peer groups may consider cultural practices when developing sexual norms, attitudes, and behaviors. Peer pressure is often considered to have a negative connotation; however, peer networks may also have a positive influence on one's sexual decision making. For instance, a peer group that has normalized safe sex practice can encourage those involved in the

peer group to also practice safe sex and maintain physical health (Tolman & McClelland, 2011). Peer groups that encourage steady dating can encourage others in their peer group to have a gradual exploration of physical intimacy, which is a beneficial factor in developing and acquiring skills for both physical and emotional intimacy (Moore & Rosenthal, 2006).

While peer groups are integral to sexual decision-making, adolescents also view them as a main source of support and knowledge of sexual issues (Smith et al., 2005). Though peers are not always a reliable source of knowledge on sexual issues, it is part of normative adolescent development to discuss issues of sexuality with peers rather than turning to parents for support and information as children often do (Moore & Rosenthal, 2006). Peers may be ideal sources for understanding and navigating normative and emotional aspects of relationships (Smith et al., 2005). Programs that help educate peer mentors on issues of sexuality have been shown to be successful because adolescents feel more comfortable asking questions when having discussions with people they can relate to (Moore & Rosenthal, 2006). A desire for acceptance by peers can influence sexual behavior, yet peers can also effectively guide each other through normative and emotional aspects of relationships (Smith et al., 2005).

Adolescence is the time of transition in which young people move away from childhood and learn how they will take on adult roles and independent decision making (Moore & Rosenthal, 2006). In terms of sexuality, “changes at the psychological level have to do with readiness for taking on adult roles, including sex and procreation” (Moore & Rosenthal, 2006). Erikson (1963) believed that adolescent romantic relationships were an important aspect in identity formation, and believed that sexual exploration in adolescence contributes to the quest for self-definition. In studying adolescent boys’ experiences of romantic relationships, Tolman, Spencer, Harmon, Rosen-Reynoso, and Striepe (2004) found that adolescent boys value the

freedom in adolescence to explore sexual feelings and the development of physical and emotional intimacy. During adolescence, cognitive changes allow for the ability to consider points of view that differ from their own (Moore & Rosenthal, 2006). Due to these cognitive changes, adolescents may be able to better understand the feelings of their partners and evaluate their peers' perceptions. In the search for one's identity in adolescence, Moore & Rosenthal (2006) state, "Learning to cope with sexuality and to place sexuality within the context of one's self-identity is an essential task for all adolescents" (p. 45).

Biological, social, and psychological changes in adolescence contribute to one's sexual development. As young people manage their emerging sense of sexuality, they "need skills to establish healthy and adaptive non-exploitative sexual relationships" (Moore & Rosenthal, 2006, p. 2). Driscoll and Russell define competence in adolescent relationships as "knowledge, efficacy, and judgment in relation to negotiating romantic relationships that are emotionally and physically healthy and satisfying for oneself and one's partner" (as cited in S. Russell, 2005, p. 6). This involves the adolescent navigating their biological changes as well as peer and romantic relationships. Adolescence is a time of identity development, which includes developing a sexual identity. Adolescents recognize that sexuality involves more than physical and biological aspects; it also includes emotional and spiritual aspects (S. Russell, 2005). Their development of sexuality occurs alongside the development of core values and personality traits (S. Russell, 2005). As the adolescent develops, they integrate the different aspects of themselves in order to develop a core identity. In relation to sexuality, Moore and Rosenthal (2006) state, "It is especially important that the adolescent be able to integrate his or her sexual feelings, needs and desires into a coherent and positive self-identity which contains, as one aspect, a sexual self" (p. 2).

Though there are potential risks in sexual behavior and exploration, many adolescents are able to navigate this time successfully. Through exploring and better understanding their sexual selves, they are able to incorporate their sexual self into their core identity. Mental health practitioners can assist adolescents in navigating their sexual development through a willingness to discuss issues of sexuality with their patients. Many adolescents believe their understandings and confusions about sex are normal, but whether they are having sex or abstaining from sex, the majority of adolescents have a desire to talk to their counselors about issues surrounding sexuality (Labor et al., 2004).

Sexuality of Psychiatric Patients

People who experience mental illness are faced with challenges that may make it difficult for them to establish romantic relationships and express their sexuality in a healthy manner. At times their mental illness may contribute to a lack of social skills necessary to establish and maintain a romantic relationship (Ace, 2007a). Symptoms such as isolation and lack of affect may make it difficult for them to connect to a partner on an intimate level (Ace, 2007a). Also, psychotropic medications used to regulate symptoms of mental illnesses can contribute to sexual issues such as “loss of desire, inability or delay in orgasm, and reduced libido” (Quinn & Browne, 2009). When people with mental illness enter a psychiatric facility or group home, there are often restrictions on sexual contact between patients (Ace, 2007a). “Sexual activity may be actively discouraged by staff concerned about liability, inconvenience, or clients’ questionable ability to give consent” (Ace, 2007a, p. 349).

Though people with mental illness face many obstacles with respect to their sexuality, they still experience sexual needs and desire sexual intimacy with others. In a study of the sexual histories of inpatient psychiatric patients, Gonzalez-Torres et al. (2010) found that 87.7% of the

546 patients included in their study reported having sexual relations at some point in their lives. About a third of these patients reported having paid for sex from a sex worker at some point in time (Gonzalez-Torres et al., 2010). This was comparable to the general population, in which about third of the general population also reported having paid for sex from a sex worker at some point in time (Gonzalez-Torres et al., 2010). The percentage of psychiatric patients who reported having any type of sexual relations in their life was 87.7%, only slightly lower than the general population percentage of 94.1% (Gonzalez-Torres et al., 2010). Sexuality is an integral aspect in the lives of people with mental illness as it is in the general population, and mental health professionals should recognize this aspect of their patients' lives.

The issue of sexuality in the inpatient setting has been addressed in contemporary literature by psychiatric nursing staff. Quinn and Browne (2009) found through a literature review that mental health patients have “a variety of sexual health concerns” and the desire to discuss these concerns with practitioners. However, the literature also revealed “nurses are poorly prepared and equipped to address the sexual health concerns of consumers” (p. 201).

Following this literature review, Quinn et al. (2011) surveyed 14 mental health nurses in order to discover their practices in relation to patient sexual concerns, attitudes on the topic of sexuality, and how their attitudes influenced their practice. The results of the surveys showed the age and gender of a patient influenced attitudes about the patient's sexuality, that potential perceptions of boundary violations prevent discussions of sexuality, and that there is a need for education for psychiatric nursing staff in order to better understand how to approach the topic of sexuality (Quinn et al., 2011). The researchers then implemented a program to educate nursing staff on the sexuality of their patients, and the process of educating staff was found to increase communication between nursing staff and patients about issues of sexuality (Quinn et al., 2013).

This study demonstrated a desire to change practices among psychiatric nurses, and encouraged a broader change in practice regarding sexuality among practitioners at psychiatric facilities. In their research, Quinn et al. (2013) pointed out that sexuality is part of the experience of being human, and in order to provide holistic care, the issue of sexuality must be addressed. Though this study focused on nursing staff, the idea of providing holistic care can be translated to other staff in psychiatric facilities, including therapists.

Sexuality in the lives of people with psychosis has been addressed through research in regard to their perceptions of sexuality. McCann (2000) did in-depth interviews with patients in a locked psychiatric hospital in order to understand the experiences, understandings, and obstacles in regards to the sexuality of people with psychosis. In responding to the interviews, respondents described intimacy as feeling wanted, cuddling, and being held along with the act of sexual intercourse, which points to their broader view of intimacy and sexuality (McCann, 2000). Volman and Landeen (2007) interviewed people with schizophrenia who live in the community and got a sense of how they integrate their sense of sexuality with their understanding and experiences with their mental illness. They found that their mental illness had a significant impact on their sexuality due to the side effects of their medications, social stigma, age of onset of their illness, and the voices they may experience as symptoms of their mental illness (Volman & Landeen, 2007). Like in the McCann study (2000), the participants in this study explained an understanding of sexuality in terms of symbolic expressions, such as hugging, cuddling, and receiving a gift (Volman & Landeen, 2007).

The social stigma associated with the sexuality of mentally ill patients may inhibit them from understanding their own sexuality. This stigma may additionally inhibit people in helping professions from approaching the subject of sexuality. The participants in the Volman and

Landeen (2007) study were able to overcome the obstacles to sexuality, and the authors point out, “when sexuality is not incorporated into the sense of self, the essence of being human is ignored” (Volman & Landeen, 2007, p. 415). This concept must encourage people in helping professions to refrain from ignoring the topic of sexuality, especially for adolescent patients, so as to address the entire essence of the patient.

Sexuality of adolescent psychiatric patients. Adverse sexual behaviors are a prevalent issue in adolescent psychiatric facilities. Hughes and Hebb (2005) studied sexual misbehavior at a forensic psychiatric facility and proposed, “some sexually offensive behaviours may be a product of disinhibition and lack of understanding or experience of how to express sexual behaviours appropriately” (p. 96). If there is a lack of understanding at the basis of sexual misbehavior, then it is plausible that an enhanced understanding and discussion of sexuality may divert some of these behaviors. Hughes and Hebb (2005) suggest that education in sexual health and relationship skills should be provided to patients before addressing sexual misbehaviors. In this they can develop awareness of their attitudes toward sex and sexuality, and they can learn to better relate to others in ways that do not involve sexual misbehaviors (Hughes & Hebb, 2005). Sexual and relationship education can also be useful for patients who do not act out through sexual misbehaviors but may be vulnerable to sexual coercion from other patients (Hughes & Hebb, 2005). As stated earlier, the majority of adolescent psychiatric patients have a history of trauma, and vulnerability to sexual coercion and a lack of understanding of healthy sexuality may stem from a trauma history, which can impact how one understands and experiences sexuality (Ace, 2007b; Kristensen & Lau, 2011; Weine et al., 1997).

Wherry, Jolly, Feldman, Adam, and Manjanatha (1995) utilized the Child Sexual Behavior Inventory and the Traumatic Antecedents Scale to find potential connections between

sexual misbehaviors and sexual abuse histories in male adolescent psychiatric patients. Though their sample size only included 23 subjects, they found that boys with a history of abuse were more likely to exhibit specific sexual behaviors relative to boys with no history of abuse (Wherry, 1995). Notably, 38% of abused boys exhibited behaviors of touching women's breasts, rubbing one's body against people or furniture, and showing sex parts to children (Wherry, 1995). Among the boys without a history of abuse, none of them exhibited these behaviors (Wherry, 1995). These are behaviors that, if exhibited in a psychiatric facility, could traumatize or retraumatize other patients. Due to the high rate of trauma exposure for adolescent psychiatric patients, it can be expected that some adolescent boys will exhibit these behaviors in psychiatric facilities (Lipschitz et al., 1999; Weine et al., 1997).

Realmuto and Erickson (1986) examined the ways in which sexual issues are managed in adolescent psychiatric facilities. They note, "Many of these young men and women have serious sexual self-image or sexual behavior problems, which may be exacerbated by the intensity and duration of their interactions on the ward" (Realmuto & Erickson, 1986, p. 347). The sexual misbehaviors may reveal underlying problems such as lack of nurturance or avoidance of adverse emotional experiences (Realmuto & Erickson, 1986). Realmuto and Erickson (1986) suggest that these sexual behaviors should be addressed in a manner that allows them to symbolically express the intense feelings associated with their sexuality. They suggest utilizing expressive therapies for symbolic expression, and art therapy may be an effective treatment modality in utilizing symbolic expression to address sexuality.

It is possible that these sexual misbehaviors are a result of the lack of means for psychiatric patients to understand and explore their sexuality, especially when these patients are adolescents with histories of trauma. Psychiatric facilities must regulate sexual misbehavior,

whether it involves a physical act or verbal expression of sexuality, due to the extensive amount of trauma history among patients and the need to protect this vulnerable population from traumatization or retraumatization (LeBel & Stromberg, 2006; Lipschitz et al., 1999; Weine et al., 1997; Weisbrot, 1986). Realmuto and Erickson (1986) suggest that regulations on sexual misbehavior should address the self-image and sexual behavior problems patients develop prior to entering the hospital. The regulations of the psychiatric hospital help patients regulate potentially harmful and impulsive sexual behavior.

Adolescent psychiatric patients may have deficits in social skills, and for patients who are used to relating to others in a sexual manner, regulations on sexual behavior provide patients with a context to learn more healthy social relationships (Realmuto & Erickson, 1986). These regulations, however, do not diminish the adolescent psychiatric patient's experience of sexuality. The sexual behaviors of patients are meaningful to them, and psychiatric facilities should respect this value while also maintaining safety for all patients (Weisbrot, 1986). Weisbrot (1986) argues that any restrictions on sexual behavior should have clear reasoning behind them, because restrictions that do not respect the inherent sexuality of adolescent psychiatric patients are unethical. Taboos surrounding adolescent sexuality may hinder exploration and understanding of sexuality, which may result in physical and sexual aggression (Realmuto & Erickson, 1986; Weisbrot, 1986). When adolescents act out through aggression, they become subject to sanctions set in place by the psychiatric facility, leading the patient to attempt to further repress sexual feelings, which creates the possibility for further acting out through aggression or sexual misbehavior.

In an article about staff countertransference in relation to the sexuality of adolescent psychiatric patients, Schneider and Deutsch (1985) point out ways in which sexuality and

identity issues in staff members can create unethical interactions with adolescent psychiatric patients. The heightened development of sexuality in the adolescent patient exasperates these issues (Schneider & Deutsch, 1985). Schneider and Deutsch (1985) suggest that the adolescent patients must work on their individual well being while in the psychiatric facility, so they may enhance their ability to enter into romantic relationships in the future. Countertransference can elicit uncomfortable feelings about one's sexuality along with worries of boundary violations with the adolescent patients, especially when the therapist finds they are experiencing sexual feeling (Schneider & Deutsch, 1985). Understanding and exploring sexuality is an integral part of adolescent development, and in order to best assist adolescent psychiatric patients in this exploration, one must first understand their own sexuality. Suggesting that patients in psychiatric facilities must fully focus on themselves is valid, but research shows that peer relationships are integral to development in adolescence (Smith et al., 2005). In allowing adolescents to explore appropriate and healthy peer relationships in psychiatric facilities, they will be working on their social and sexual development.

Sex education programs in psychiatric facilities are becoming more common, but often anxiety from the psychiatric staff about implementing these programs can create obstacles. Leichtman (1990) highlights the necessity for sex education with adolescents in psychiatric facilities; "All adolescents need accurate information, opportunities to correct misconceptions and fantasies, and help in coming to terms with how their sexuality affects their experience of themselves and their relationships with others, the needs of disturbed teenagers are even greater" (p. 34). When exploring anxiety that psychiatric staff had about sex education with adolescent patients, Leichtman (1990) found that staff members were mostly concerned with their own lack of openness about and exploration of sexuality. Staff members were not overly concerned about

sexual misbehaviors developing as a result of the sex education (Leichtman, 1990). Once hospital staff was educated about the sexuality of their patients, they became more comfortable in implementing sex education courses (Leichtman, 1990). Leichtman's (1990) study reveals that sex education can be successfully implemented into treatment programming once psychiatric staff are adequately educated. Though there may initially be resistance in implementing the exploration of sexuality into treatment, this resistance may originate in misconceptions of staff rather than concern about patient reactions.

McCann (2000) points out that discussing issues of sexuality with patients is complex and involves moral, ethical, and legal dilemmas. Discussing sexuality with psychiatric patients can create concern over accusations of sexual misconduct and real or perceived boundary violations (Quinn et al., 2011). Practitioners in psychiatric facilities may also have concern about their own views of sexuality conflicting with the views of the patient (McCann, 2000). Despite these concerns, McCann (2000) calls for a serious consideration of addressing issues of sexuality in health and social care. Educating staff on the sexuality of psychiatric patients has been shown to diminish concerns surrounding discussions of sexuality (Quinn et al., 2013). There seem to be many adverse consequences to suppressing an understanding of sexuality, and through addressing this topic some adverse acting out that results from such suppression may be eliminated.

Challenges of Sexuality Development for Adolescent Psychiatric Patients

While adolescence is a difficult time for anyone, patients in psychiatric facilities face unique challenges as they reach puberty and begin the process of sexuality development. Adolescent sexuality is a taboo subject, and the added stigma against sexuality of the mentally ill may further prevent acknowledgment of the sexuality of this population (Cook, 2000; Realmuto

& Erickson, 1986). Abnormal peer relationships and restrictions on peer interactions regarding sexual contact and discussion can alter the process of sexuality development for psychiatric patients (Weisbrot, 1986). A history of trauma can affect the perception of sexuality for psychiatric patients and may make it more difficult for patients to experience a healthy sense of sexuality (Ace, 2007b; Kristensen & Lau, 2011). The connection between trauma and sexuality should have significant consideration when addressing the sexuality development of adolescent psychiatric patients, and this connection will be further explored in subsequent sections of this literature review. Practitioners must find a way to assist adolescents in psychiatric facilities in navigating the unique personal and social challenges of these adolescents so they may develop a healthy sense of sexuality comparable to adolescents outside of psychiatric facilities.

People with mental illnesses are often perceived as asexual or unable to have healthy sexual relationships due to impaired judgment (Rowe, 2007). This perception is inaccurate, and empirical research has shown that psychiatric patients have a sense of sexuality and feel sexuality is an aspect of their core selves (McCann, 2000; Rowe, 2007; Volman & Landeen, 2007). Practitioners in psychiatric facilities can look to these studies to better understand the sexuality of their psychiatric patients and correct misconceptions about their adolescent psychiatric patients, who are in the process of sexuality development.

Adolescents who experience mental illness may face challenges in establishing romantic relationships. Seefeldt, Florsheim, and Benjamin (2003) found that an adolescent's mental illness should be taken into consideration when assisting them in navigating relationships. Adolescents with psychological disorders may be more likely to become involved in unhealthy romantic relationships (Seefeldt et al., 2003). The stress involved in romantic relationships such as jealousy and neglectfulness could become problematic for a mentally ill adolescent (Seefeldt et

al., 2003). The stress of the relationship could exacerbate symptoms, and symptoms of the adolescent's mental illness could become the source of stress in the relationship for the adolescent's partner (Seefeldt et al., 2003).

Seefeldt et al. (2003) suggested a system of teaching adolescents to manage romantic relationships that takes into account difficulties associated with mental illness. This system was based on focusing on others, focusing on self, and intrapsychic focus. It addressed aspects of relationships such as self-blame, trust, and active love. This model is meant to facilitate change in dysfunctional adolescent relationships and allows for enhanced success in navigating romantic relationships. Seefeldt et al. (2003) believed that "romantic relationships among adolescents often play an important role either by diminishing the influence of previous negative events on developmental outcomes or by contributing new problems to the developmental process" (p. 179). This suggests that a healthy romantic relationship may play a role in diminishing negative consequences of trauma that relate to relationships and sexuality (Ace, 2007b). Adolescent psychiatric patients in residential facilities can benefit from learning potential pitfalls in romantic relationships that can be associated with their mental illness. They will not have the typical experience of an adolescent romantic relationship while in the facility due to restrictions on intimate contact with other patients. The facility can help prevent dysfunctional adolescent romantic relationships in preparing patients for healthy romantic relationships following discharge.

Typically, adolescents have ample opportunities to socialize with peers of the opposite sex. For heterosexual adolescents, this may allow them to explore their attraction to the opposite sex and learn how to develop friendships and romantic relationships with these peers (Feirig, 1999). For adolescents in psychiatric facilities, there is limited contact with the opposite sex.

Lopez (2000) studied adolescents' experiences of psychiatric hospitals through interviews with adolescent psychiatric patients. She found that the adolescents "overwhelmingly expressed their interest in the opposite sex" (Lopez, 2000, p. 79). The adolescents enjoyed interacting with opposite sex peers during coed activities, and this interaction was considered an important aspect of their hospitalization (Lopez, 2000). Interacting with peers of the opposite-sex increases during adolescence, and this seems to be an important aspect in developing romantic relationships (Feirig, 1999). Through coed experiences in psychiatric facilities, adolescents may be able to explore how they relate to the opposite sex, a significant aspect of the development of romantic relationships and sexuality.

Exploring the physical aspects of one's sexuality is fundamental in sexual development and in learning how to navigate and develop intimate relationships (Moore & Rosenthal, 2006; Welsh et al., 2005). In psychiatric facilities, there are limitations on physical and sexual contact as well as discussing topics pertaining to sexuality with peers (Adams, McClellan, Douglass, McCurry, & Storck, 1995; Weisbrot, 1986). These limitations are put in place for reasons associated with the significant history of trauma experienced by this population, which can limit their ability to maintain appropriate boundaries with others (Adams et al., 1995; LeBel & Stromberg, 2006; Lipschitz et al., 1999; Weine et al., 1997). To prevent patients from developing inappropriate boundaries with other patients, there are restrictions on physical touch with other patients. Rappaport and Minahan (2013) outline ways in which trauma can affect interactions between children in a classroom, and these concepts apply to the necessity of regulations in adolescent psychiatric facilities. If a patient touches another patient with trauma history, either patient may re-experience adverse incidents, which could be harmful for their mental health (Rappaport & Minahan, 2013). Psychiatric facilities must create an environment that provides

clear and predictable rules about physical boundaries so the adolescent or child who has experienced trauma knows their environment is safe (Rappaport & Minahan, 2013).

Though these restrictions are put into place for the patients' safety, they also restrict patients from progressing through sexual development in the ways that non-psychiatric patients do. During normative sexual development, physical touch towards peers becomes gradually more intimate and allows adolescents to explore and discover their sexuality while also allowing for the adolescent to learn how to be in a long-term relationship (Moore & Rosenthal, 2006). Because adolescents in psychiatric facilities do not have the opportunity to experience physical and intimate touch, practitioners who work in long-term facilities may want to consider ways that their patients can develop these skills while also maintaining the safety of all patients.

Peer groups provide emotional support and knowledge on sexual issues during adolescence and are an influence on sexual norms, attitudes, and behaviors (Smith et al., 2005; Tolman & McClelland, 2011). Peer relationships in adolescent psychiatric facilities are viewed as sources of emotional support and socialization much like peer relationships outside of psychiatric facilities (Lopez, 2000). In psychiatric facilities, discussing sexual issues with peers is typically considered sexual misbehavior (Adams et al., 1995). This leaves adolescents in psychiatric facilities lacking in this normative behavior because they cannot seek out support and acceptance regarding sexuality in the same way as adolescents who are not in psychiatric facilities. These rules must remain in place in order to protect patients from potentially traumatizing discussions and possibly exploitive situations (Weisbrot, 1986). The necessity of these rules leaves practitioners to question how their patients could gain the benefits of this normative behavior while also protecting their patients from harmful situations. A potential

solution to this is to provide adolescent psychiatric patients with a safe space to explore their sexuality.

Psychological Trauma

Trauma, abuse, and severe maltreatment have a significant impact on one's neurological, psychological, and social development. Trauma is defined by the American Psychiatric Association (2013) as an incident in which a "person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (p. 271). This study will consider the effects of traumatic events including physical abuse, sexual abuse, emotional abuse, witnessing domestic violence, witnessing community violence, and neglect. This does not include some traumatic events such as experiencing physical injury that results in a traumatic brain injury. Adolescents in psychiatric facilities are exposed to a variety of traumas and have a higher rate of trauma exposure than the general population. About 80% to 90% of adolescent psychiatric patients are exposed to at least one traumatic event, while about 40% of adolescents in the general population are exposed to at least one traumatic event (Giaconia et al., 1995; Kilpatrick & Saunders, 1999; LeBel & Stromberg, 2006; Lipschitz et al., 1999; Weine et al., 1997). Research studies about outcomes of trauma specify the type of trauma they are addressing, and some studies analyze the outcomes of a variety of trauma. An exhaustive study of the impact of trauma is beyond the scope of this paper as there has been an expansion of research on the neurological, psychological, and social effects of trauma in recent years that has provided a more thorough understanding of the impacts of trauma (Braquchais, Picouto, & Casas, 2012; Crawford, 2010; Schore, 2009; Shin & Handwerger, 2009; Walter, Palmieri, & Gunstad, 2010). Trauma should be considered when working with adolescent psychiatric patients

to explore sexuality due to the high rate of trauma exposure among adolescent psychiatric patients and the effects of trauma on sexuality.

Psychological trauma and the brain. Posttraumatic stress disorder (PTSD) is a psychiatric diagnosis attributed to people who have experienced trauma and exhibit a variety of debilitating symptoms including intrusive symptoms, avoidance symptoms, and negative alterations in cognition and mood (American Psychiatric Association, 2013). People with PTSD have been found to have lower levels of cortisol and higher levels of norepinephrine than people without PTSD, and the imbalance of these hormones can lead to an enhanced reactive response to perceived threatening stimuli (van der Kolk, 2002). The brain is then trained to react to fear-inducing stimuli in a certain way, especially to stimuli that are related to traumatic experiences. This reaction to fear-inducing stimuli following trauma typically involves either an “overengagement with trauma-related information, typified by extreme reexperiencing and hyperarousal, and/or pathological emotional underengagement with trauma-related information,” which could lead to dissociation (Hopper, Frewen, van der Kolk, & Lanis, 2007, p. 723). The HPA axis may be connected to hyperarousal in response to fear-inducing stimuli that occurs as a result of early traumatic experiences (Schoore, 2009).

The way the brain reacts to fear-inducing stimuli must be taken into consideration when providing a space for adolescent psychiatric patients to understand and explore their sexuality. After experiencing trauma, one loses a sense of safety and the brain has difficulty distinguishing safety from danger (van der Kolk, 2002). If sexuality is a fear-inducing stimulus for the adolescent, they may experience retraumatization through overengagement or they may disengage, or disassociate, during the process. In a study by Hopper et al. (2007), their analysis of the way the brain reacted to their trauma narrative showed that an increase in avoidance may

have indirectly increased reexperiencing. Their findings supported previous studies that found a failure of fear extinction in people with PTSD, and were consistent with the experience of emotional dysregulation among people with PTSD (Hopper et al., 2007).

Braquehais et al. (2012) evaluated the literature on childhood emotional neglect and proposed it may be the “most silent but most destructive aspect” of other types of abuse due to its impact on the developing brain (p. 125). Child maltreatment, which is a form of trauma, can lead to an inability to inhibit negative actions and an inability to modulate emotions (Braquehais et al. 2012). This knowledge supports Hopper et al.’s (2007) understanding of the neurological changes that result from traumatic experiences. It also shows how trauma and sexuality may be connected; for instance, an adolescent who is developing sexual impulses may have more difficulty controlling these impulses due to the effects of trauma.

Psychological trauma and mental illness. Patel, Fisher, Hetrick, & McGarry (2007) found that experiencing trauma is a risk factor for developing mental illness for adolescents. Mental illness is an extreme burden on the adolescent age group, and it is estimated that “at least one out of every four to five young people in the general population will suffer from at least one mental disorder in any given year” (Patel et al., 2007, p. 1303). Violence and child abuse are major risk factors in the development of a mental illness (Patel et al., 2007). Abuse and trauma can be linked to feeling a lack of control, and the risk of suicide among mentally ill adolescents can be understood in the context of a this loss of control, over both their environment and their emotions due to the effect of trauma on the brain (Patel et al., 2007; van der Kolk, 2002). Trauma can then lead to mental illness, a lack of control, and psychiatric hospitalization for young people. Adams et al. (1995) found a high rate of abuse of severely mentally ill youth, and

expressed that “it is expected that other populations would not have the degree of abuse histories” (p. 564). Rowe (2007) reiterates this:

The psychosocial history of many institutionalized psychiatric patients reveals numerous instances of early sexual abuse and conflict regarding sexual orientation or normal developmental milestones. These circumstances provide a rationale for prohibiting sexual expression when what is needed in many cases is sex education, guidance, and support (p. 88).

This is not to say that everyone who enters psychiatric hospitalization has experienced trauma or visa versa, but the effects of trauma should be considered when treating adolescent psychiatric patients, especially when approaching the topic of sexuality.

Psychological trauma and sexuality. Research about sexual abuse (SA) shows that adolescents with a history of sexual abuse are more likely to have at least one psychiatric diagnosis than those who have not experienced SA, resulting in the understanding that “SA has a wide-ranging psychological impact, even when compared to that of other teens with psychiatric difficulties” (Houck, Nugent, Lescano, Peters, & Brown, 2010, p. 479). Kristensen and Lau (2011) found in collecting data from women with a history of childhood sexual abuse (CSA) that these women were unlikely to be satisfied with their current sexual life. They also found that both a lack of having a supportive adult in childhood and having a history of a combination of physical abuse and CSA lead to more sexual problems in adulthood (Kristensen & Lau, 2011).

Though the study by Kristensen and Lau (2011) focuses on difficulties in sexuality of women who are sexually abused, Ace (2007b) expands on this by outlining sexual difficulties that could result from various types of trauma, including sexual abuse, physical abuse, psychological maltreatment, and neglect. As a result of abuse, one could have difficulty

establishing intimacy for fear of safety or through modeling combative behaviors (Ace, 2007b). Avoidant behaviors that develop as coping strategies in response to trauma can impact sexuality (Ace, 2007b). They may prevent the person from processing the traumatic events, leading to a continuation of emotional difficulties (Ace, 2007b). Avoidance of intense emotions can lead to difficulties in problem-solving in relationships (Ace, 2007b). Some people may become hypersexual in response to trauma in order to feel physical closeness and as a result of lacking the means to develop emotional intimacy (Ace, 2007b). Due to these maladaptive coping strategies, people who have experienced trauma may have difficulties connecting to a romantic partner through sexuality, or they may be able to only connect to a partner through sex (Ace, 2007b).

In studies about sexual misbehavior in psychiatric settings, researchers have found that adolescents who demonstrate sexual misbehaviors often have a history of traumatic experiences. Hargrave (1991) suggested that as severe and complex diagnoses in adolescents and children in psychiatric facilities increase, which may include higher incidents of trauma histories, the number of incidents of sexual misbehavior may also be rising. Through a series of workshops, Hargrave (1991) gathered information from staff that worked in residential psychiatric facilities in order to better understand the types of incidents of sexual misbehavior that had occurred in these facilities. Throughout the 95 incidents that were reported, Hargrave (1991) found that “the pattern of incidents clearly follows the expected course of sexual development, with higher rates of heterosexual incidents in adolescent treatment environments and higher rates of homosexual incidents in child settings” (p. 416). Due to this pattern, Hargrave (1991) suggested educating psychiatric staff on typical ways adolescents and children explore their sexuality so that they may address these incidents in the most therapeutic manner possible. Hargrave (1991) also

suggested a consideration of trauma history in addressing incidents of sexual misbehavior, and pointed out that children who have been molested may recreate the situation of the abuse by sexualizing relationships with staff in order to gain mastery over the previous trauma. If sexual misbehavior is addressed through the exploration of sexuality through art therapy, Hargrave's (1991) suggestion of a consideration of trauma should inform treatment planning.

In order to explore the link between sexual misbehavior and trauma, Adams et al. (1995) completed a 5-year retrospective review of charts of 499 youth in inpatient and day treatment programs in order to find incidents of sexual misbehavior that occurred either previous to hospitalization or during hospitalization. They found that there were "372 incidents of sexually inappropriate behaviors reported in 202 subjects" (Adams et al., 1995, p. 559) and divided these incidents into three categories: "hypersexual (flirtatious, touching), exposing (public masturbation, self-exposure), and victimizing (molestation, incest, and/or rape)" (p. 558). Subjects who demonstrated sexual misbehaviors had significantly higher rates of physical and sexual abuse compared to the nonoffending group (Adams et al., 1995). The study also highlights that overall there was a high rate of abuse histories for all patients included in the study, and 36% of the nonoffending group in the study had a history of sexual abuse, meaning sexual abuse may be predictive of sexual misbehavior, but it is not an inevitable result of sexual abuse (Adams et al., 1995).

Trauma informed care. A review of research about the effects of trauma shows that trauma exposure can result in various neurological, psychological, and social disturbances. As researchers continue to find connections between trauma exposure and mental health disorders, it has become necessary to provide psychiatric patients with care that addresses the impacts of trauma. Trauma-informed care (TIC) protocols have been developed to ensure that agencies that

treat people who have been exposed to trauma meet the needs specific to this population. TIC as it is defined for behavioral health services as “an intervention and organizational approach that focuses on how trauma may affect an individual’s life and his or her response to behavioral health services from prevention to treatment” (U. S. Department of Health and Human Services [DHHS], 2014, p. 11). There are three elements that organizations focus on when implementing TIC: “realizing the prevalence of trauma, recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce, and responding by putting this knowledge into practice” (DHHS, 2012).

When an organization implements a TIC framework, staff members are trained at all levels of an agency to understand how “safety, trustworthiness, choice, collaboration, empowerment, skills acquisition, empathy, and relationships” contribute to healing the effects of trauma (Hummer, Dollard, Robst, & Armstrong, 2010, p. 89). Mental health practitioners who work under the framework of trauma-informed care recognize the impact of trauma on their patients and understand that maladaptive behavior may be a coping mechanism or response to the trauma they have experienced (DHHS, 2014). Through an understanding of trauma, mental health practitioners can work to eliminate the potential for re-traumatization and address the ways in which trauma may have impacted their mental health.

While TIC aims to meet the needs of patients who have experienced trauma in all aspects of an organization, trauma-specific services address specific symptoms and disorders related to trauma. Trauma-specific services include trauma-focused therapies that provide the patient the opportunity to address their experience of trauma in the therapeutic environment. Trauma-specific services allow patients to better understand their experience of trauma and cope with their experience of trauma more effectively. Hummer et al. (2010) identifies the goals of trauma-

specific services as the following: “achieving safety in one’s environment, developing skills in emotion regulation and interpersonal functioning, making meanings about traumatic events, and enhancing resiliency and integration into a social network” (pp. 81-82). Through a literature review on TIC practices in youth residential treatment, Hummer et al. (2010) re-iterates the principle of TIC by highlighting the need for an organizational change that accounts for the traumatic experiences of patients, which goes beyond providing trauma-specific services.

The research explored in this literature review reveals traumatic experiences can potentially impact many areas of one’s life, and most importantly for this study it has the potential to affect the way one experiences and expresses sexuality. Adolescents who enter psychiatric facilities are likely to have experienced trauma at some point in their lives (Havens et al., 2012; LeBel & Stromberg, 2006; Lipschitz et al., 1999; Weine et al., 1997). Treatment that addresses the sexuality development of adolescent psychiatric patients can use the principles of TIC in order to avoid re-traumatization. Through addressing sexuality development with adolescent psychiatric patients under the framework of TIC, the patient can develop an enhanced sense of safety and empowerment in regards to their sense of sexuality.

Art Therapy and Trauma

Research that has been done on the use of art therapy with people who have experienced trauma can support the use of art therapy with sexuality. The American Art Therapy Association (2014) defines art therapy as follows:

Art therapy is a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to *explore their feelings, reconcile emotional conflicts, foster self-awareness* [emphasis added], manage behavior

and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.

Using art therapy to explore sexuality can allow the patient to explore their feelings connected to sexuality and foster self-awareness. It can also help patients to reconcile emotional conflicts related to their sexuality that have developed from trauma. Art therapists use media choices to elicit cognitive or emotional processing of topics during therapy, and these media choices are based on the expressive therapies continuum (ETC). The ETC conceptualizes media choices based on a spectrum from fluid media to resistive media (Hinz, 2009). Fluid materials allow the patient to express emotions, while resistive materials allow the patient to contain emotions (Hinz, 2009). When using art therapy to process trauma, art therapists can use the ETC to balance the need of the patient to explore their experience of trauma with the need of the patient to avoid overwhelming or unmanageable emotions.

Because of the impacts of trauma on the experience of sexuality, research on using art therapy to address trauma should be considered when using art therapy to explore sexuality with adolescent psychiatric patients who have experienced trauma. The literature on using art therapy for people who have experienced trauma can provide guidance for developing a treatment plan to explore sexuality and provides support for the reduction of symptoms related to trauma, which may include a reduction of adverse experiences related to sexuality development.

Art therapy has been found to be effective in the treatment of trauma; for instance, Klorer (2005) explained how the understanding of traumatic memories stored in the right side of the brain supports the use of art therapy as treatment for maltreated children. In order to work through traumatic memories, Klorer (2005) stated, "It makes sense to help the child make use of right-brain functions where the trauma memories are stored to express and work through issues

of severe maltreatment in a way that supports the child's cognitive, developmental, and emotional levels" (p. 217). Gantt and Tinnin (2009) gathered research about mechanisms of art therapy and the neurological and psychological effects of trauma to support art therapy as an effective treatment for people who have experienced trauma. Because trauma is stored in the right side of the brain, people who have had traumatic experiences may have difficulties eliciting words and order to traumatic memories (Gantt & Tinnin, 2009). When people experience trauma, an instinctual reaction causes an interruption in verbal consciousness, located in the left side of the brain, and one experiences the event through sensory knowledge, located in the right side of the brain (Gantt & Tinnin, 2009). Trauma can therefore interrupt communication between the right and left side of the brain (Gantt & Tinnin, 2009).

Gantt and Tinnin (2009) discussed how art therapy provides a means of accessing the right side of the brain because it "provides a means for communication with the nonverbal mind" (p. 151). Gantt and Tinnin (2009) also proposed that the disruption in communication between the right and left hemispheres results in an inability to understand the time and sequence associated with the traumatic event, and the victim may feel the traumatic event is continuously happening even when it has ended. Therapeutic interventions for trauma survivors must address this lack of temporal understanding. Gantt and Tinnin (2009) explained that the healing properties that art therapy provides in treating people who have experienced trauma includes "restoring a sense of temporal order, promoting narrative closure, making traumatic events past tense, imbuing nonverbal material with verbal description, and recontextualizing fragmented experience" (p. 152).

Crenshaw (2006) also gathered information in order to examine how research on the neurological effects of trauma can inform and support the use of art therapy in treating people

who have experienced trauma. Crenshaw (2006) presented research that demonstrates the right side of the brain is crucial in attachment functioning and coping strategies in response to stress. Early traumatic experiences can disrupt the ability of the brain to develop attachment and coping strategies (Crenshaw, 2006). In summarizing the findings of the effects of early traumatic experiences, Crenshaw (2006) stated,

The stress response system is of crucial importance to all living beings; it enables the efficient and adaptive response to threat and danger. If, however, a person, and particularly a young child, who is more vulnerable due to emerging development, is exposed to extreme or long-lasting stress, alterations in the neural circuits and biologic systems involved in response to stress are likely to take place. (p. 23)

Crenshaw (2006) further explained why art therapy might be particularly useful in trauma treatment. For example, exploring metaphor through art to process trauma can provide psychological distance and may allow for an enhanced feeling of safety relative to direct verbal confrontation (Crenshaw, 2006). The patient has the opportunity to talk about the artwork rather than their own personal experiences. Establishing safety is a vital aspect of trauma treatment, because exposure to trauma diminishes one's sense of safety (Pifalo, 2002). Many art therapy treatment programs that target trauma stress the establishment of safety throughout treatment (Backos & Pagon, 1999; Lyshak-Stelzer, Singer, St. John, & Chemtab, 2007; Pifalo, 2002; Sweig, 2000). Also, exposure to trauma can result in damage to emotional areas of the brain dominating cognition (Crenshaw, 2006). Due to this, children exposed to trauma will process nonverbal information more effectively than verbal information (Crenshaw, 2006). Therefore, they may be able to process and integrate nonverbal therapy, such as art therapy, more effectively than verbal therapy. Van der Kolk's theories about trauma treatment provide support

for utilizing art therapy in trauma treatment in that he recommends newer therapies that are less language reliant because verbal therapies cannot release the trauma victim from body memories (as cited in Crenshaw, 2006).

Pifalo (2002) has studied the efficacy of art therapy in the context of working with children who have experienced sexual trauma. She has found that art therapy can effectively reduce symptoms associated with sexual trauma; art therapy specifically was shown to significantly decrease anxiety, posttraumatic stress, and overt dissociation (Pifalo, 2002).

Lyshak-Stelzer et al. (2007) also studied the effects of art therapy on symptoms associated with PTSD. In a study involving random assignment, the authors found that trauma-focused art therapy (TF-ART) reduced symptoms of PTSD significantly more than a standard arts-and-craft-making activity group that had previously been implemented at the facilities that participated in the study (Lyshak-Stelzer et al., 2007). In another study that treated sexually abused latency age girls through art therapy, Powell and Faherty (1990) found

By placing the overwhelmingly negative aspects of the abuse into perspective, each girl begins to form a more integrated understanding of her victimization and can begin to relate to herself and her environment in a more positive, powerful, and productive manner. (p. 47)

The results of the findings of Pifalo (2002), Lyshak-Stelzer et al. (2007), and Powell and Faherty (1990) suggested that the decrease in symptoms associated with trauma as a result of art therapy can lead to a more broad and positive experience of relating to oneself and one's environment. This directly relates to one's experience of healthy sexuality, which relies on the ability to negotiate relationships that result in a positive experience for oneself and one's partner (S. Russell, 2005).

In a 30-year longitudinal study, Spring (2004), like Pifalo (2002), studied the use of art therapy with victims of sexual trauma. She gathered artwork produced by victims of rape, victims of multiple instances of sexual abuse, and a control group (Spring, 2004). After analyzing 255 drawings, she found that victims seem to use a unique artistic language. Spring (2004) linked her findings to the use of symbols as a way in which victims can neurologically integrate the effects of trauma. She proposed that the evidence she found of an artistic language supports the ability for art therapy to transform “unsymbolized sensory knowledge to symbolized visual form” (Spring, 2004, p. 207).

Art therapy has consistently demonstrated to be an effective approach in treating trauma, and more research continues in order to further establish how the neurological underpinnings of art therapy support the effectiveness of this treatment. The exploration of the use of art therapy in treating people with traumatic histories can assist in understanding how art therapy can be used with adolescent psychiatric patients in order to explore and understand sexuality. Since traumatic experiences may affect how one experiences and expresses sexuality, art therapy may have the potential to reduce adverse experiences and expressions of sexuality as it has been shown to reduce other symptoms and effects of trauma (Ace, 2007b; Kristensen & Lau, 2011; Lyshak-Stelzer et al., 2007; Pifalo, 2002; Powell & Faherty, 1990). Researchers emphasize how the nonverbal nature of art therapy allows patients to access information in the right, nonverbal side of the brain, and this makes it a particularly effective treatment for trauma in that it allows for an exploration and better understanding of traumatic memories (Crenshaw, 2006; Gantt & Tinnin, 2009; Klorer, 2005). Like traumatic memories, sexuality is experienced nonverbally; therefore, the neurological theories and research that supports using art therapy in the treatment of trauma

may also support applying art therapy in exploring and understanding sexuality (Bancroft, 2010; van der Kolk, 2002).

Art Therapy and Sexuality

Evidence in research has shown that art therapy can be used to better understand one's sexuality. Ambrogne-O'Toole (1988) created two women's groups, one with psychiatric patients and another with professional women and graduate students with the intention of allowing the groups to explore their sexuality. In these groups, women were able to explore through art and discussion experiences they had as adolescents, including their first experience of menstruation and relationships during this period in their lives. The first experience of menstruation was the focus of many of the groups because the author "view[ed] this area of female nature as a powerful symbol of identity and as a potential force in shaping feelings about female sexuality" (Ambrogne-O'Toole, 1988, p. 115). Ambrogne-O'Toole (1988) found that using expressive therapies allowed for an understanding of one's sexuality that went beyond a verbal or educational understanding, and the group atmosphere promoted a sense of mutual experience of negative emotions that could then be put into a new perspective.

Sexuality is an aspect of one's self that is difficult to define and understand, which is congruent with the theory that our sexuality is based in the limbic system, a part of the brain that controls emotions and is difficult to understand consciously or verbally (Bancroft, 2010; van der Kolk, 2002). Research demonstrates that art therapy may be an avenue to explore sexuality, which is further supported by the sexual symbolism that appears in artwork (Wadeson, 1975). Wadeson (1975) suggested that it may not be necessary to point out the aspects of sexuality that appear in artwork due to the mistakes and projections that result from the therapist's personal experiences with sexuality and sexual symbols. The patient's expression of a sexual symbol and

the therapist's interpretation of such symbol may differ (Wadeson, 1975). Also, a premature or inadequate interpretation of an expression of sexuality in artwork may be met with heightened defensiveness (Wadeson, 1975). Wadeson (1975) suggests that at times the patient's creation of the sexual symbol provides them with exploration that is adequate without the addition of verbal processing. When the patient uses sexual symbols in their artwork, they may be accessing the area of the brain connected to sexuality, which Wadeson (1975) suggests adequately provides an avenue of exploration of sexuality (Bancroft, 2010; van der Kolk, 2002).

In connecting liminality, art therapy, and childhood sexual abuse, Haywood (2012) discussed the state of adolescence as a period of transition, which she identified as a liminal space, and how childhood sexual abuse can enhance the ambiguity of this transitional period. Liminality is a term rooted in social anthropology, and refers to a transitional phase involved in rites of passage and life events such as marriage, death, and childbirth (Haywood, 2012). Rites of passage typically involve stages of separation, transition, and incorporation, and the stage of transition is connected to liminality (Haywood, 2012). Liminality can also be conceptualized as a state of limbo in which one is neither dead, or finished with one life stage, nor alive, or beginning a new life stage (Haywood, 2012). Adolescence can be conceptualized as a liminal space, in which one is no longer a child and not yet an adult. Liminality is a state of ambiguity, and children who are sexually abused can be considered to be in a liminal space in that they are still a child but have experienced sexuality at an unusually early age (Haywood, 2012). "Abused children are exposed to sexual experiences and knowledge not typically encountered until adolescence or young adulthood. They are therefore 'old before their time' in a sexual sense" (Haywood, 2012, p. 82).

Haywood (2012) suggested that art therapy can be an effective tool in assisting adolescents in moving through this liminal space, and supported the role of the art therapist as a witness to this work, “By looking at images and ‘hearing’ the visual testimonies contained within them, art therapists help their young clients to share, acknowledge and value material that is normally considered taboo” (p. 85). Because victims of childhood sexual abuse are exposed to sexual experiences at an early age, and these experiences are traumatic, their understanding of sexuality is complicated by the young age of their experience and the negative feelings surrounding this experience. Working through experiences of childhood sexual abuse may allow the adolescent to begin to conceptualize sexuality in a positive and normative manner and overcome adverse effects on their sexual development from an early negative sexual experience. Haywood’s (2012) theory of using art therapy to move through a liminal space can be applied more broadly to adolescence. As adolescents move through their liminal space into adulthood, art therapists can assist this movement by witnessing and encouraging an exploration of ambiguous topics such as sexuality and trauma.

Adolescents in psychiatric facilities have restrictions on their ability to explore and understand their sexuality, and these restrictions may lead to adverse sexual behaviors (Realmuto & Erickson, 1986; Weisbrot, 1986). Weisbrot (1986) points out that any sexual behavior by an adolescent psychiatric patient is meaningful to them. In exploring theoretical ways in which adolescents could healthily explore and express their sexuality, Weisbrot (1986) explains:

Sexual learning is organized around the sensual experience of the body and distorted self-images during this period may be the basis of subsequent personality defects. The ability of the severely impaired adolescent to translate his sexual turmoil into the creative modes

of expression is often quite limited. One sees physical aggression and sexual misbehavior substituted in its place. (p. 33)

Weisbrot's (1986) conceptualization of sexual learning seems to directly support art therapy as a means for exploration and understanding sexuality. The body is actively involved in creating art and art therapy elicits a sensory experience. Art therapy can provide the sensory experience the adolescent psychiatric patient is lacking due to restrictions surrounding sexuality. These sensory experiences may be an adequate substitute for the typical "sensual experiences of the body"

Weisbrot (1986) connects to sexual learning. Weisbrot (1986) also connects the lack of creative modes of expression of sexuality to physical aggression and sexual misbehavior; therefore, one could theorize that provision of a creative mode to express sexuality could diminish physical aggression and sexual misbehavior. Realmuto and Erickson (1986) make a similar recommendation in suggesting the use of various expressive therapies in the incorporation of the exploration of sexuality into psychiatric treatment.

The act of creating artwork that reveals aspects of our sexuality may in and of itself allow us to elicit our sexual selves and better integrate this understanding into our understanding of ourselves (Junge, 1987). Whether it be in a group setting that creates universality or in the context of sexual symbolism that appears unconsciously in artwork, there are benefits in connecting to one's sexual self through artwork, and this may be an ideal means of evoking the sexual self due to the parallel of the nonverbal nature of creating and the nonverbal nature of our understanding of sexuality (Ambrogne-O'Toole, 1988; Bancroft, 2010; Wadeson, 1975).

Summary

Adolescent psychiatric facilities aim to provide holistic care to their patients, which should include care for the patients' sexual selves. While there has been research about the

necessity of providing support for issues of sexuality in these facilities (Quinn & Brown, 2009; Quinn et al., 2013), this research is typically focused on adults. There may be an even greater need, though, to provide this care for adolescents in psychiatric facilities due to the changes they encounter during puberty, the high likelihood the adolescent has experienced trauma, and the impact of trauma on sexual development.

Adolescence is a time of identity development, which includes developing a sexual identity. Adolescents in psychiatric facilities experience unique challenges in this stage of development. Many adolescents who enter psychiatric facilities have experienced at least one traumatic event (Lipschitz et al., 1999; Weine et al., 1997). In order to protect the safety of all patients and decrease the likelihood of traumatization or retraumatization, physical touch and discussions of sexual issues between patients are restricted. Though these restrictions are put into place for the patients' safety, they also restrict patients from progressing through sexual development similar to non-psychiatric patients. Exploring the physical aspects of one's sexuality is integral in sexual development and in learning how to navigate and develop intimate relationships (Moore & Rosenthal, 2006; Welsh et al., 2005). In normative sexual development, peers provide emotional support for issues of sexuality, but due to restrictions in psychiatric facilities the ability for adolescent psychiatric patients to seek peer support during sexuality development is diminished (Smith et al., 2005). Practitioners must find a way their adolescent psychiatric patients can experience the benefits of normative sexual development while maintaining the safety of all patients.

At this time of developing sexuality, traumatic experiences may further complicate the issues of understanding sexuality and controlling impulses that may lead to sexual misbehaviors (Wherry et al., 1995). Early sexual abuse may alter one's experience of sexuality in that it seems

to eroticize children, while other types of trauma also impact the way one relates to self and other (Ace, 2007b; Wherry et al., 1995). Research shows that adolescents who have been abused are more likely to exhibit sexual misbehaviors, which may further retraumatize them or other patients when they are in a psychiatric facility (Wherry et al., 1995). Wherry et al. (1995) and Hargrave (1991) found that a history of trauma correlated with sexual misbehaviors in adolescent psychiatric patients. Weisbrot (1986) suggested a lack of understanding and exploration of sexuality leads to sexual misbehaviors.

An understanding of the impact of trauma on sexuality may connect these findings. CSA results in early exposure to sexual experience, and this early exposure could lead to a heightened misunderstanding of sexuality (Haywood, 2012). Potential impacts of trauma related to sexuality such as avoiding intense emotions, avoiding intimacy, and hypersexuality may also result in a heightened misunderstanding of trauma (Ace, 2007b). Restrictions of adolescent psychiatric facilities also play a role in restricting the exploration of sexuality of adolescent psychiatric patients. In conceptualizing sexual misbehavior as a result of a lack of understanding of sexuality, trauma may enhance this lack of understanding in tandem with restrictions on discussions and expressions of sexuality of adolescent psychiatric facilities. When psychiatric facilities implement sanctions for sexual misbehaviors, they may not be addressing the underlying problem and instead promote repression of sexuality. Encouraging a repression of sexuality through sanctions opposes suggestions of researchers that the exploration of sexuality leads to healthy sexual development, and may reduce sexual misbehaviors (Moore & Rosenthal, 2006; Realmuto & Erickson, 1986; Weisbrot, 1986). Placing sanctions on sexual misbehaviors without exploring underlying issues leads to repression of sexuality and the potential for further sexual misbehaviors.

Neurological functions exist that connect the experiences of puberty, trauma, and sexuality. The HPA axis may be connected to hyperarousal in response to fear-inducing stimuli that occurs as a result of early traumatic experiences (Schore, 2009). The HPA axis is affected by changes to brain chemistry during puberty (Biro & Dorn, 2006). The limbic system is also involved in the experience of sexuality, the changes experienced during puberty, and alterations that result from traumatic experiences (Bancroft, 2010; Biro & Dorn, 2006; van der Kolk, 2002). When combined, the adolescent psychiatric patient's brain is going through many changes that may be difficult to understand and reconcile, especially since the changes are located in an area of the brain that is based in emotional and sensory understanding rather than verbal and logical understanding (Bancroft, 2010; Biro & Dorn, 2006; van der Kolk, 2002). Art therapy accesses the nonverbal part of the brain, and in using art therapy to explore sexuality the patient can better process these nonverbal experiences (van der Kolk, 2002).

Art therapy has been shown to be effective in treating trauma and understanding sexuality due to the nonverbal nature of this therapy. Any treatment that addresses the sexuality of adolescent psychiatric patients must also address experiences of trauma because the experience of sexuality is directly affected by traumatic experiences (Ace, 2007b; Kristensen & Lau, 2011). Through art therapy, the patient can access the area of the brain that stores the understandings and experiences of both trauma and sexuality. It is proposed that in accessing this area of the brain and in better understanding one's sexual impulses, one will have more power to control these impulses (Grenadier, 1995). Also, since sexual misbehavior may be a result of trauma (Wherry et al., 1995), it is possible that art therapy may be able to decrease sexual misbehavior as it has been shown to decrease other effects of trauma (Pifalo, 2002).

Adolescents have expressed the desire to discuss issues of sexuality with their counselors (Labor et al., 2004), yet there has been little research on the experience of sexuality for adolescents in residential psychiatric facilities who have experienced trauma. The research that has been done calls for an approach that involves metaphors and symbolism in the exploration of sexuality (Realmuto & Erickson, 1986; Weisbrot, 1986). Art therapy offers this type of approach, and would be able to address the complex intermingling of trauma and sexuality. Once issues of sexuality are addressed, these patients may display a more integrated sense of self and refrain from exhibiting sexual misbehaviors and thus avoid traumatizing or retraumatizing themselves or other patients.

Chapter IV: Results

This study describes how art therapy can be used as a means to explore sexuality and assist in reducing sexual misbehaviors for adolescents in a residential psychiatric facility.

Through an integrative literature review, an understanding of theory and research surrounding art therapy, residential psychiatric facilities, adolescents, sexuality, and trauma are explored in order to formulate suggestions for this treatment.

Following is a specific art therapy treatment plan including directives and materials for the purpose of exploring sexuality with adolescents in a residential psychiatric facility who have experienced trauma. This treatment plan has been developed specifically to be used by art therapists. Art therapists are master's level clinicians who are trained to use art materials and the creative process in the context of therapy to elicit therapeutic growth. This treatment plan is based in art therapy theory and requires training in art therapy to effectively and therapeutically assist adolescent psychiatric patients who have experienced trauma through the process of exploring sexuality. The directives included are supported by the research in the integrative literature review. The treatment plan outlined is not to be considered all-inclusive, as alterations with findings from previous literature kept in mind could still meet the same goal.

Outline of Treatment Plan

For the duration of this treatment plan, the patient will keep a journal of questions or experiences they encounter between sessions. The journal provides an ongoing space for the exploration of sexuality. The treatment plan outlines the goal, materials, directive, follow-up questions, and rationale for each session. The goals, directives, and follow-up questions are supported by conclusions developed from the literature review, which is outlined in the rationale section. Each session addresses aspects of trauma that relate to sexuality, and art therapists

should be cognizant of the different connections between trauma and sexuality that could surface throughout the implementation of the treatment plan. By addressing the effects of trauma on sexuality, this treatment plan takes into consideration the principles of TIC, which calls for a focus on “how trauma may affect an individual’s life” when implementing treatment interventions (DHHS, 2014, p. 11). A psychoeducational component is included in each session. Normative sexuality development comes with confusion about topics related to sex, and art therapists have an opportunity to provide a space for questions and education about sexuality (Labor et al., 2004). Art therapists should be knowledgeable about sexuality and know how to access resources when questions from patients go beyond the scope of the art therapist’s knowledge. Through psychoeducation, patients are able to obtain accurate information and correct misconceptions about sexuality, which is important for adolescents when coming to terms with their personal experience of sexuality (Leichtman, 1990). The psychoeducation component can provide a starting point for the personal exploration of sexuality through art making.

The Expressive Therapies Continuum (ETC) developed by Kagin and Lusebrink (1978) will inform media choices used throughout this treatment plan. The ETC conceptualizes media choices based on a spectrum from fluid media to resistive media (Hinz, 2009). Fluid materials allow the patient to express emotions, while resistive materials allow the patient to contain emotions (Hinz, 2009). In order to promote a sense of control over expression, this treatment plan offers three choices of art materials and paper sizes for each session. The patient will be provided a choice of 4.5” x 6”, 9” x 12”, or 12” x 16” white paper for each session. This offers the patient the opportunity to decide how much space they need for their artistic expression. Art materials provided differ in sessions based on the need for containment or expression of

emotions. For the first two sessions, the art therapist will provide collage materials, colored pencils, and markers. These materials promote cognitive processing rather than affective processing (Hinz, 2009). It is important early in therapy that safety is established that the patient does not become overwhelmed with emotions, because they may feel too vulnerable (Pifalo, 2002). According to Hinz (2009), materials that are less resistive, such as oil pastels and chalk pastels, promote more affective processing. The third session introduces oil pastels into material choices, providing the opportunity for patients to explore the topic of sexuality on a more affective level. In the fourth fifth, and sixth sessions, markers, oil pastels, and chalk pastels will be provided. At this point in the treatment plan, the materials provided are less resistive to encourage affective processing. In using a less resistive material while exploring the patient's relationships to others, they can connect to the sensations in their body and their emotions connected to sexuality. The final session again includes collage materials in order to promote a containment of emotions as the treatment plan comes to a close. Along with collage materials, the patient is provided markers and oil pastels. These less restrictive materials will allow some affective processing of healthy sexuality and allows the patient's brain to integrate their emotions and the concept of healthy sexuality.

Session 1. Intro/Safety

Goal: To establish a sense of safety in the art therapy session and explore the concept of safety as it applies to sexuality and trauma.

Psychoeducation: This session begins with a discussion of boundaries that keep the patient's body safe. This includes ways in which others can make them feel unsafe verbally or through physical touch or closeness. The therapist will explain to the client that during this treatment plan they will be asked to explore some difficult concepts that

relate to their traumatic experiences. The theme of safety will continue throughout this treatment plan. It is important to discuss the patient's power to assert their right to feel safe in their body and in their sexuality. Through the directive, they can then expand on their personal ideas about ways to keep their body safe.

Materials: Collage materials, colored pencils, and markers

Directive: Create a collage that shows ways you can create and maintain safe boundaries.

Follow-up Questions or Directives: How might boundaries differ in different relationships? Why is it important to maintain safe boundaries?

Rational: It is vital to establish safety in the initial session and throughout treatment. Art therapy treatment plans that address trauma emphasize initial establishment of safety, and due to the connections between trauma and sexuality this treatment plan addresses safety in the initial session (Ace, 2007b; Backos & Pagon, 1999; Lyshak-Stelzer et al., 2007; Pifalo, 2002; Sweig, 2000). Traumatic experiences lead to a diminished sense of safety, and in establishing a sense of safety when confronting issues related to trauma, the adolescent's brain may be less likely to react through hyperarousal or disassociation (Hopper et al., 2007; Rankin & Taucher, 2003).

Session 2. Defining Sexuality

Goal: To explore the patient's personal definition of sexuality, including the positive, negative, and unknown aspects of sexuality.

Psychoeducation: This discussion assists the patient in developing their definition of sexuality. The patient can conceptualize sexuality beyond the physical act of sex. The patient will be asked to consider positive and negative aspects of sexuality and how their life experiences have influenced their conceptualization of sexuality. The art therapist

should be open to initial questions about sexuality and offer the opportunity to discuss questions as they develop throughout treatment. After discussing the different components of sexuality, the patient will have the opportunity to explore their personal definition of sexuality through the directive.

Materials: Collage materials, colored pencils, and markers

Directive: Create a collage that shows your personal definition of sexuality.

Follow-up Questions or Directives: What do you value about sexuality? What is scary or unclear about sexuality? Does a sense of sexuality always involve more than one person?

Rational: This directive allows adolescents to explore their personal definition of sexuality, which typically goes beyond the physical act of sex (S. Russell, 2005).

Sexuality development is integral to identity formation in adolescence (Tolman & McClelland, 2011). This directive allows them the space to explore their sexual identity. It also addresses some of the negative associations they may have as a result of trauma (Ace, 2007b; Kristensen & Lau, 2011).

Session 3. Safety in sexuality

Goal: To explore how patients can maintain safety in regards to the physical and emotional aspects of sexuality.

Psychoeducation: This session will begin by reviewing session one and the ideas the patient had about safe boundaries. The patient will then apply their ideas about maintaining safe boundaries to their definition of sexuality that was developed in session two. The art therapist will provide information about undesirable outcomes of sexuality, such as STIs and becoming vulnerable to people who are unsafe, while emphasizing the

patient's right to keep their sexuality safe. The art therapist will continue to assist the patient in understanding ways in which trauma impacts sexuality.

Materials: Colored pencils, markers, oil pastels

Directive: Draw a symbol that represents the self and a boundary that keeps it safe from trauma and undesirable outcomes of sexuality.

Follow-up Questions or Directives: Does your boundary allow for anything to access the image? Will trauma try to cross the boundary?

Rational: This directive addresses information about undesirable outcomes of sexuality, which allows the patient to become more knowledgeable about and in control of their sexuality and sexual behavior. Providing patients with knowledge of undesirable outcomes of sexuality addresses their desire to discuss issues of sexuality while in treatment (Labor et al., 2004; Quinn & Browne, 2009). This directive uses the boundary around the self to address the connection between sexuality and trauma. In working through these difficulties, the adolescent may begin the process of working through the impact of trauma on their sexuality in hopes that they will avoid future difficulties with sexuality (Ace, 2007b; Kristensen & Lau, 2011). Art therapy may be able to reduce the consequences of adverse sexual experiences due to trauma as it has been shown to reduce other symptoms related to trauma (Lyshak-Stelzer et al., 2007; Pifalo, 2002; Powell & Faherty, 1990).

Session 4. Safety in relationships with friends

Goal: To explore the facets of friendships and the necessity of safety in friendships.

Psychoeducation: The patient and therapist will discuss how the patient defines a friend and the different levels of closeness and intimacy in friendships. They will then discuss

the different challenges that present in friendships, and how to best address these challenges. The patient can then think of a time a friendship became unsafe or a friend crossed a boundary, and how this was similar to their trauma. Through the directive, the patient can then chose to explore ways friendships can help them maintain healthy sexuality or how friendships can violate the safety of their sexuality.

Materials: Markers, oil pastels, and chalk pastels

Directive: Think back to the boundary you created for the sexuality symbol. Draw a friend either helping to guard this boundary from trauma or trying to break the boundary with trauma.

Follow-up Questions or Directives: What are some important characteristics of a safe friend? How is intimacy with a friend different from intimacy with a partner?

Rational: This directive allows the adolescent to explore how friendships are integrated into their sexuality development (Smith et al., 2005). Healthy peer relationships can assist adolescents in navigating emotional aspects of intimate relationships and normative sexuality development (Smith et al., 2005). This directive also emphasizes the value of safety in the context of friendships. Adolescents who have a history of trauma can be vulnerable to sexual coercion, so it is important to emphasize safety and boundaries in friendships for adolescent psychiatric patients (Hughes & Hebb, 2005).

Session 5. Safety in relationships with partners

Goal: To explore the facets of a relationship with an intimate partner and the necessity of safety in these relationships.

Psychoeducation: The patient and therapist will discuss how the patient defines an intimate partner and ways intimate partners can experience closeness and intimacy. They

will then discuss the different challenges that present in relationships with intimate partners, and how to best address these challenges. The art therapist will explain different ways that the added intimacy of partnerships can be hindered or unsafe due to the adolescent's experience of trauma. The art therapist will assist the patient in developing ideas about how to communicate their need for safety in partnerships.

Materials: Markers, oil pastels, and chalk pastels

Directive: Using line, shape, and color, make a drawing that represents the emotions involved in an intimate partnership. Then, draw a protective boundary around the emotions you want to keep safe from trauma or undesirable outcomes of sexuality.

Follow-up Questions or Directives: What are some difficulties in developing intimate relationships? How might a healthy relationship help you develop your identity?

Rational: Intimate relationships in adolescence assist in identity development and provide adolescents with the opportunity to explore developing sexual feelings (Erikson, 1963).

For an adolescent psychiatric patient, the opportunities to explore these feelings are limited. Once the adolescent psychiatric patient leaves the psychiatric facility, their mental illness presents challenges for intimate relationships (Seefeldt et al., 2003). This directive allows the adolescent to explore feelings associated with intimate relationships and challenges that they may face. It also addresses the impact their traumatic experiences will have on their intimate relationships. This directive addresses the need for safety in intimate relationships. The patient may feel vulnerable when entering into an intimate relationship due to previous boundary violations associated with trauma Hughes

& Hebb, 2005). This directive is aimed to empower the adolescent with a feeling of control and safety when entering into intimate relationships.

Session 6. Healthy Sexuality

Goal: To combine their exploration of sexuality into a conceptualization of healthy sexuality.

Psychoeducation: The patient and art therapist will begin this session by reviewing what was discussed in previous sessions and what the patient connected with in previous sessions. The art therapist will give some definitions describing healthy sexuality and ask if the patient has additional ideas about healthy sexuality. The patient will also suggest ways in which sexuality can be unhealthy that due to the impacts of trauma. A discussion of what healthy sexuality *is not* may help they patient define healthy sexuality. They can then identify what is most important for them to experience healthy sexuality through the directive.

Material: Collage, Markers, Oil Pastels

Directive: Draw a map indicating the steps you will take to develop and maintain a healthy life. Indicate how healthy sexuality is a part of this map and indicate potential obstacles along the way.

Follow-up Questions or Directives: What emotions are connected to healthy sexuality? How is healthy sexuality personally beneficial?

Rational: As adolescents develop their sense of sexuality, they must learn how their values and desires regarding sexuality can be integrated into their self-identity (Moore & Rosenthal, 2006; S. Russell, 2005). This directive can integrate understandings about relating to others, trauma, bodily experiences, and positive and negative consequences of

sexual experiences that have been explored throughout this treatment plan. In exploring the concept of healthy sexuality, the adolescent can discuss ways to experience sexuality in a way that is non-exploitive and satisfying for themselves and future partners (Moore & Rosenthal, 2006; S. Russell, 2005).

Chapter V: Discussion

Overview of Results

Based on the findings of this literature review, an outline of an art therapy treatment plan has been developed that can be implemented with adolescents in residential psychiatric facilities who have experienced trauma. It is recommended that this plan be utilized with a significant background of knowledge in the areas of adolescent sexuality and trauma and how these issues can be addressed through the use of art therapy. This type of knowledge was addressed through the integrative literature review and reiterated as supporting information for the directives outlined in the treatment plan.

This literature review found that the sexuality of adolescent psychiatric patients must be considered when providing holistic care in psychiatric facilities. Though adolescents and people who are mentally ill are often viewed as asexual, researchers are working to correct these misconceptions (Rowe, 2007). Sexuality development is integral in the process of identity development during adolescence, and adolescents have similar experiences of sexuality as adults (Fortenberry, 2013; Moore & Rosenthal, 2006; S. Russell, 2005). Mentally ill adults have typical sexual experiences and desires, but mental illnesses present obstacles to the experiences of sexuality for adults and adolescents (Gonzalez-Torres et al., 2010; McCann, 2000; Seefeldt et al., 2003). Because sexuality development is integral in identity development, therapists must work to assist adolescents in psychiatric facilities to integrate their sense of sexuality into their sense of self. The literature that outlines normative sexuality development and the experience of sexuality of mentally ill adolescents supports the need for treatment that cultivates healthy, normative sexuality development of adolescent psychiatric patients who have experienced trauma.

The literature review provided information about the unique experience of sexuality development of adolescents in psychiatric facilities who have experienced trauma. Sexual misbehaviors in psychiatric facilities may be a behavioral indication of the adolescent psychiatric patient's altered experience of sexuality development. Many factors seem to contribute to the likelihood for an adolescent to exhibit sexual misbehaviors, including experiencing trauma and lacking the means to explore sexuality (Realmuto & Erickson, 1986; Weisbrot, 1986; Wherry et al., 1995). Adolescents in psychiatric facilities often have a history of trauma, and studies have found trauma has an impact on how one experiences sexuality (Ace, 2007b; Kristensen & Lau, 2011; Lipschitz et al., 1999; Weine et al., 1997).

The treatment plan presented intends to address the factors that may hinder adolescent psychiatric patients from normative sexuality development with the intention of reducing incidents of sexual misbehaviors. The literature suggests that allowing adolescent psychiatric patients to explore their sexuality may reduce sexual misbehaviors (Weisbrot, 1986). Art therapy may be the ideal means to address this need because one's experience of sexuality is a sensory experience and located in the limbic system of the brain, which makes it difficult to verbalize (Bancroft, 2010; van der Kolk, 2002). Art therapy activates the limbic system of the brain, and may provide a deeper understanding of sexuality than verbal therapy (van der Kolk, 2002).

Using art therapy as a means to explore sexuality aims to assist adolescent psychiatric patients in overcoming challenges they face pertaining to normative sexuality development. This task takes into consideration the resiliency of adolescents who have experienced trauma. Though research shows that trauma can negatively affect sexuality, therapeutic interventions may prevent the development or continuation of these negative outcomes. Restrictions in psychiatric facilities surrounding the expression of sexuality hinder normative sexuality development, but providing

patients with a space to explore their sexuality can help adolescent psychiatric patients successfully progress through normative sexuality development. Psychiatric facilities aim to increase resiliency so that patients can overcome the obstacles of their mental illnesses and live fulfilling lives (Hair, 2005). Gaining an understanding of sexuality through art therapy assists in increasing the resiliency of adolescent psychiatric patients and provides them with the tools to embrace their right to experience healthy sexuality. An adolescent's traumatic history does not condemn them to an unsatisfactory experience of sexuality, and therapeutic interventions can assist adolescent psychiatric patients in overcoming negative consequences of trauma, including its effect on their experience of sexuality.

Limitations

There are limitations in this study as well as in the potential implementation of the treatment plan. The literature was found and analyzed by the researcher, so there is always potential for a bias of research included as well as a bias in analysis. This bias was addressed through a conscious attempt to include all relevant information and consider all points-of-view that were presented in the literature.

The topic of sexuality is considered taboo, especially in terms of adolescent sexuality and the sexuality of the mentally ill. Institutions and practitioners may not be accepting of executing this treatment plan with adolescent residential psychiatric patients. This is another reason why a strong foundation in the research on the topic is necessary, because questions from the institution and other practitioners may be addressed and a constructive dialogue can ensue about the potential benefits and limitations of such treatment.

It should be noted that this work is theoretical and this specific treatment plan has not been implemented in a clinical setting. The treatment plan outline is not to be considered all-

inclusive, as alterations with considerations of findings from previous literature could still attain the same goal. It may be appropriate for art therapists to use alternative art materials when applying the presented treatment plan. For example, if the art therapist has worked with a patient long enough to understand their needs and limitations regarding materials, it may be appropriate to use materials that are more or less resistant. If the patient is easily flooded with emotions during a session, it may be ideal to use markers or colored pencils for directives that suggest using oil and chalk pastels. For patients who could manage a more emotional exploration of the topic of sexuality, using paint for the directives that suggest oil and chalk pastels could allow a deeper exploration of the connection of sexuality to one's bodily and emotional experiences. Art therapists may also decide to explore additional topics based on individual needs of the patient. This treatment plan intends to highlight general needs for the development of adolescent sexuality, and any alterations that address these needs could be effective in providing a means to explore sexuality for adolescent psychiatric patients who have experienced trauma.

Implications for Future Research

The treatment plan presented in this thesis focuses on developing a sense of safety in sexuality in order to provide the patient with an in-depth exploration of the topic of safety as it pertains to sexuality. A foundational understanding of safety is integral in treatment with patients who have experienced trauma (Lyshak-Stelzer et al., 2007; Pifalo, 2002; Rankin & Taucher, 2003). The treatment plan also provides a space to explore and understand topics relevant to sexuality development. Art therapists have an opportunity to use the information found in this literature review to expand the treatment plan presented in this thesis and provide the patient with an opportunity to explore additional topics related to sexuality. Topics not covered in this treatment plan include the experience of psychological and physical changes during puberty, the

experience of sexuality in the body, and the way sexuality fits into personal identity. The exploration of sexuality need not be limited to six art therapy sessions. With the information provided in this literature review, art therapists have the opportunity to provide adolescent psychiatric patients with a continuous safe space for the development of knowledge and exploration of topics pertaining to sexuality.

Psychiatric facilities aim to “shape desirable behaviors and emotional responses,” and research on treatment outcomes of psychiatric facilities must base success on measurable changes in the patient (Hair, 2005, p. 555). This literature review identified a reduction in sexual misbehavior as a potential outcome of using art therapy as a means to explore sexuality with adolescent psychiatric patients with a history of trauma. Because psychiatric facilities measure change based on patient behavior, future research of the effectiveness of an art therapy program that focuses on sexuality should align with philosophy. Though some research questions the lasting effects of behavior-based treatment, the literature on sexual misbehaviors of adolescent psychiatric patients promotes the use of education and exploration of sexuality development to produce behavioral changes (Frensch & Cameron, 2002). If future research provides a measurable behavior outcome that results from the use of art therapy to explore sexuality, psychiatric facilities can use art therapy to address the core issues of sexual misbehaviors and influence a change in behaviors.

Chapter VI: Conclusions and Recommendations

Through the literature review, some major findings support the use of art therapy as a means of exploring sexuality with adolescent psychiatric patients who have experienced trauma. One major finding is that adolescent psychiatric patients have a desire to discuss issues of sexuality in treatment. This is based on the understanding that adolescence is a time in which major sexual development occurs, and adolescents experience sexuality similar to adults (Auslander et al., 2006; Fortenberry, 2013). In previous research, adolescents as well as adults with mental illnesses have voiced a desire to address issues of sexuality in treatment (Labor et al., 2004; Quinn & Brown, 2009).

Another major finding is that art therapy is an optimal way in which sexuality can be explored in that it elicits the nonverbal part of the brain, where our experience of sexuality resides (Ambrongne-O'Toole, 1988; Bancroft, 2010). The limbic system is involved in the experience of sexuality, the changes experienced during puberty, and alterations that result from traumatic experiences (Bancroft, 2010; Biro & Dorn, 2006; van der Kolk, 2002). An integration of traumatic experiences and an understanding of sexuality can both be addressed through art therapy (Gantt & Tinnin, 2009). Due to the connection that exists between traumatic experiences and sexuality, therapeutic interventions that address sexuality should address both sexuality and trauma (Ace, 2007b; Kristensen & Lau, 2011).

The findings in this literature review intend to provide art therapists with information to assist them in working with their adolescent psychiatric patients who have experienced trauma. It is recommended that art therapists apply the provided treatment plan or a similar treatment plan in their practice with adolescent psychiatric patients who have experienced trauma. If art therapists decide to implement such a program in their practice, it is highly recommended that

they document the process in their own research practice in order to note the outcomes of the treatment plan as they occur. If an art therapist decides to document implementation of this type of treatment plan, the use of media should be thoroughly documented so that it can provide guidance for future art therapy treatment plans that address sexuality. In studying the presented treatment plan and any similar treatment plans, one can further the study of exploring sexuality with adolescent residential psychiatric patients and better understand how art therapy can address sexuality and trauma in order to reduce sexual misbehavior.

This treatment plan was developed with consideration of the needs of adolescent psychiatric patients who have experienced trauma. Other adolescents could also benefit from the exploration of sexuality through art therapy. Developing sexuality is a task for all adolescents, and adolescents have expressed a desire to discuss issues of sexuality with their counselors (Labor et al., 2004). Adolescents in psychiatric facilities are not the only individuals who have questions regarding sexuality nor are they the only population who struggle with sexual misbehaviors. A treatment plan that explores sexuality through art therapy could support other adolescents who are attempting to navigate the biological, social, and psychological changes that contribute to sexuality development.

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